

Yorkshire Ambulance Service NHS Trust

Yorkshire Ambulance Service NHS Trust HQ






Quality Report

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Good	
Emergency and urgent care services	Good	
Patient transport services (PTS)	Requires improvement	
Emergency operations centre	Good	
Resilience planning	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, an NHS 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and emergency operation centres (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a resilience and hazardous area response team (HART).

We carried out a focused follow up inspection of the trust from 13-16 September 2016, in response to a previous inspection as part of our comprehensive inspection programme of Yorkshire Ambulance Service NHS Trust in January 2015. In addition, an announced comprehensive inspection of the NHS 111 service was carried out on 10-12 October 2016.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

We inspected five core services:

- Emergency operations centres
- Urgent and emergency care
- Patient transport services
- Resilience services including the Hazardous Area Response Team
- NHS 111 services.

Overall, we rated all of the five key domains as good which meant the overall rating for the trust was also good.

Our key findings were as follows:

- The trust had undertaken a number of initiatives to improve staff engagement; the staff forum had become embedded since our previous inspection and was viewed positively by staff.
- Relationships between the trust and trade unions had improved since the previous inspection but there still more work for the trust to do.
- Staffing levels throughout the trust were planned and monitored. The trust had challenges due to national shortages however; it was addressing this through a range of initiatives.
- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. There were no performance targets for the ARP pilot. The trust monitored its performance on response times.
- At the previous inspection there had been concerns in relation to equipment checks, maintenance of equipment and consumable stock. At this inspection we found the trust had put in place a system to ensure equipment and stock was suitable to use.
- In most of the core services we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean. However there were still inconsistencies in the way staff maintained vehicle cleanliness across the PTS service.

Summary of findings

- There were systems in place to share learning from incidents and adverse events. Most staff we spoke with confirmed they received feedback by email after reporting an incident. A safety bulletin was produced and shared across the trust to share lessons learnt.
- There were high levels of compliance with safeguarding training at levels one and two and all staff who were determined by the trust to require level three training in relation to their role, had received this.
- From April 2016 the trust had commenced a local review of mortality and morbidity, supported by local audits linked to the trust's commissioning for quality and innovation (CQUIN) targets to explore all deaths in the care of the trust, where Recognition of Life Extinct (ROLE) had been invoked by YAS paramedics.
- Within the NHS 111 service, call abandonment rate was 2%, compared to the national average of 3%. We saw that 89% of calls were answered within 60 seconds, compared to the national average of 87%.
- Within the PTS service there was a clear lack of management oversight and lack of ownership of roles and responsibilities, and governance systems were not fully embedded throughout the service.

We saw several areas of outstanding practice including:

- The rapid arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The restart a heart team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. More than 300 community first responder schemes worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which were available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.
- The trust had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme had won a 'Pharmacy Innovation' award.
- The NHS 111 service had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life.
- The trust had made use of a comprehensive workforce management tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation was recognised by a National Planning Award from the Professional Planning Forum.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

In addition the trust should:

Summary of findings

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.
- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating

Good



Why have we given this rating?

At our previous inspection in January 2015, the service was rated as Requires Improvement overall. In September 2016 we rated this core service as Good because:

- The trust had put in place processes for risk management and clinical governance of the service. Risks were rated and a review date specified which showed each risk was recently reviewed.
- Positive changes to the executive leadership of the service were recognised and appreciated by staff; the chief executive was seen as approachable.
- The trust was participating in the national trial of the ambulance response project (ARP) which helped the service to dispatch appropriate ambulance resources to patients.
- Outcomes for patients had improved; for example practice to support the return of spontaneous circulation (ROSC) and involvement with regional and national sepsis networks had strengthened the sepsis pathways and improved clinical quality outcomes.
- Staff worked closely with hospital providers of emergency and other providers of services including fire and rescue and community responders to coordinate appropriate pathways of care for patients.
- Staff were able to report incidents readily and learning from the investigation of incidents was shared.
- Infection control procedures were followed and ambulance stations and vehicles were clean. A vehicle “make ready” service had been introduced in some stations. There were plans to introduce this across the service.
- Equipment and consumable supplies were readily available and arrangements for disposing of out of date items were in place.
- The workforce plan developed during 2016-17 reflected demand profiles for each area and

Summary of findings

- planned workforce numbers and recruitment were monitored weekly. The workforce plan was communicated and understood by staff which helped to support retention.
- Records contained appropriate and sufficient information about the patient and their condition and were fully maintained and audited.
 - Patients with deteriorating conditions were identified promptly and escalated for appropriate treatment. Pathways for assessing and responding to patients who experienced trauma, suffered from chest pain or experienced a suspected stroke were followed.
 - Medicines were stored securely and administered safely. Oxygen and analgesic gases were secured securely and were in date. Secure storage for medicines was also maintained in acute hospitals. We saw medicines cabinets were securely locked with access only permissible by ambulance service crews. Controlled medicines were stored in ambulance stations in a locked room within a locked safe and the room was alarmed.
 - The learning and development of staff was supported. All staff new to the service received thorough induction and training and the service was taking steps to ensure staff received an annual appraisal and clinical supervision. Most staff had completed their mandatory training.
 - The culture of the service had improved. Public engagement for the service had developed and included roadshows and community partnership events. Local engagement events had attracted more than 3,000 members of the public. Consultation arrangements with staff included a newly established multi union partnership and the staff forum was embedded.
 - Staff knew how to deal with complaints they received, complaints were investigated and we found some evidence that learning was shared with staff. For the 12 months prior to our inspection the service had met agreed due dates in 96% of cases and has achieved an

Summary of findings

average response time of 21 working days for all services. The service had a standard of 85% for quality audit outcomes, and was achieving 86% at the time of our visit.

- Innovation was encouraged through support for national initiatives and locally based research projects.

However:

- The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.
- The recording of medicines administration contained some discrepancies which were not always identified through audit procedures. At an emergency department we visited, when we checked the stock of controlled medicines, we found the items issued had been audited incorrectly, so that one item was shown incorrectly as in surplus. The service addressed this issue at the time of our visit.
- Records were not always securely stored on ambulance vehicles. We raised this with the trust during our visit and at our unannounced inspection we found that procedures had been changed to protect the security of records.
- It was not always possible for ambulance crews to access secure vehicle seating for children.
- Disposal of clinical waste and sharps was variable in a minority of vehicles and ambulance stations.
- Further work was needed to ensure a target number of staff (at least 85%) received an annual appraisal. The service had in place a recovery plan to achieve 90% appraisal rates by 2017-18.
- Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews.
- Front line staff we spoke with could not articulate the vision and strategy for the service.

Summary of findings

Patient transport services (PTS)

Requires improvement



We undertook a comprehensive inspection of the Yorkshire Ambulance Service (YAS) in January 2015. At this time, we rated Patient Transport Services as Requiring Improvement in the domains of safe, effective, responsive and well-led. We rated the caring domain as Good.

- There had been some improvements to incident reporting and there were also some systems in place to monitor risks. However, there was a lack of robust processes and management oversight to ensure staff had learned from incidents or complaints.
- There were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks.
- There had been some improvements in the maintenance and cleaning of vehicles and the replenishment of equipment vehicles. However, there was inconsistency in what was stored on vehicles and where it was stored. Storage of some equipment was not safe and posed a risk to patients. There were also unsafe vehicles in use and fault reporting was not robust.
- In some localities we found vehicle security to be poor which was a risk to the service.
- There were systems to monitor quality and performance. There had been some improvements in the service's performance against some of the key performance indicators. However, concerns remained regarding the performance targets not being met for some renal dialysis patients and within the communications and control centre.
- There continued to be staffing vacancies in the communications and control centre. This had a negative impact on patient experience and other stakeholders contacting the service. This also had an impact on the planning and scheduling of patients' return journeys.
- The business continuity plans for the communication and control centre were not well developed despite actions being identified from a table top exercise in October 2015.

However:

Summary of findings

- Most staff told us they felt proud to work for the trust. Patient transport service (PTS) staff felt their immediate operational managers supported them in their role, although there were some reports of a disconnection between staff and senior managers.
- There were robust plans in place for fluctuations in demand, staffing shortages and for adverse weather conditions.
- The compliance rates for mandatory training and staff appraisals showed a significant improvement from our last inspection.
- During the course of our inspection, we saw examples of staff demonstrating a caring and compassionate approach to supporting patients. We observed patients dignity being maintained and patient being treated in a respectful way. We also received some very positive feedback from patients and their carers regarding the PTS staff who demonstrated a real commitment to delivering a good service.

Emergency operations centre

Good



Overall, the service was rated as Good. This was because:

- The emergency operation centre (EOC) used an evidence based clinical triage system to assess patients.
- They had access to a language interpreter service and text relay service for patients with impaired hearing.
- Paramedic and mental health support and advice were available.
- Staff knew how to report safeguarding concerns. Safeguarding referrals could be made 24 hours a day through the clinical hub
- Staffing levels were scheduled and planned on an electronic system, which took into account previous demand data and forthcoming events.
- Governance processes were in place and there were clear governance structures. Risk registers were reviewed and management were able to describe the current risks to the EOC.
- The culture of the service was open and transparent and staff told us they received good support from their team leaders and duty managers.

Summary of findings

- The trust had been involved in a number of initiatives, such as 'The Blue Light' programme. The aim of the programme was to improve the mental health of staff working in emergency service by having 'Blue Light Champions' to act as support to staff.
- The service was one of the leading organisations in the piloting of the Ambulance Response Programme (ARP) introduced in April 2016. ARP aimed to improve response times to critically ill patients by ensuring an appropriate response to patients first time.
- Incidents were reported, investigated and lessons learnt shared with staff across the organisation. Although the majority of staff received feedback from incidents, there were inconsistencies as some staff had not always received individual feedback. This was also the findings at the previous inspection.

However we also found:

- Not all staff using the evidence based clinical triage system were up to date with basic life support (BLS) training. Up to date training was a requisite for a licence in the use of the system. Following the inspection the trust wrote and assured CQC that by the 1 December 2016 85% of the EOC staff would have BLS training. They also informed us that they had recently been re-accredited by the International Academy and given centre of excellence status. Training on BLS instructions within the dispatcher role was part of the criteria for re-accreditation.
- Not all nursing staff were up to date with safeguarding training.

Resilience planning

Good



Overall we rated resilience at YAS as Good. Safe and well-led was rated as Good and effective was rated as Outstanding.

- We found good evidence of learning both in local and wider resilience teams. This was supported by good systems for reporting incidents and debriefs.

Summary of findings

- Mandatory training levels had been met or exceeded. Staff were able to demonstrate their knowledge around mental capacity and safeguarding.
- Significant improvements had been made with regards to checking equipment and the cleanliness of the environment and vehicles. This had been sustained since the previous inspection.
- Medications management practices were safe.
- Staffing levels were good and in line with national guidance.
- Business continuity plans were robust and the service assessed and responded well to potential risks, service demand and capacity.
- Staff were actively engaged in activities to monitor and improve quality and patient care. Care was evidence based and opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- Staff were proactively supported to acquire new skills and share best practice and we were provided with many examples of this. Staff competencies were maintained and tested in accordance with National Ambulance Resilience Unit (NARU) recommendations.
- A number of Hazardous Area Response Team (HART) operatives were specialists in particular core competencies such as chemical, biological, radiological and nuclear (CBRN), and safe work at height incidents (SWAH) and provided training and updates to colleagues.
- Staff were patient focused in terms of care planning and delivery, with a commitment to collaborative working based on Joint Emergency Services Interoperability Programme (JESIP) principles which were embedded within the service.
- Information was collated and shared in performance dashboards and in ResWeb which all staff had access to. Information was also shared via a database, 'PROCLUS' from national bodies such as NARU.

Summary of findings

- There was a clear vision and strategy for the service which was stretching and supported by staff. This linked to the overall trust vision as well as national guidance.
 - There was active engagement with a variety of other organisations and a strong focus on collaborative working.
 - Leadership was strong at all levels with experienced and knowledgeable staff in post. There was a focus on continuous improvement and motivation of staff towards a shared purpose.
 - It had been identified from the previous inspection the changes in practice in some areas needed to be made. It was identified these could not be brought about by an individual person. All staff were involved and accountable for the changes in practice.
 - There was a very positive culture within the teams and staff morale was high. There were high levels of engagement with staff, and staff were encouraged to raise concerns.
 - The governance arrangements and information related to performance were proactively reviewed.
-

Yorkshire Ambulance Service NHS Trust HQ

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience;

Detailed findings

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Background to Yorkshire Ambulance Service NHS Trust HQ

Yorkshire Ambulance Service NHS Trust (YAS) was formed on 1 July 2006 when the county's three former services merged. The trust covers North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The trust employs over 4,670 staff and provides 24-hour emergency and healthcare services to a population of more than five million. YAS is the only NHS trust that covers the whole of Yorkshire and Humber.

The trust provided an accident and emergency (A&E) service to respond to 999 calls, patient transport services (PTS) and emergency operation centres (EOC) where 999 calls were received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There is also a Resilience and Hazardous Area Response Team (HART). The trust also provided an NHS 111 core service for when medical help is needed fast but it is not a 999 emergency. This core service was inspected in October 2016 and is included in this report.

In 2015-16 the trusts received 2.6 million calls and responded to 854,966 urgent and emergency calls. The NHS 111 service received 1,511,038 calls for the year which averaged at 4,139 calls per day. Within PTS in 2015-16 the service made around 1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

The trust covers a population of approximately five million people and ethnic diversity ranged from 1.9% to 18.2% of the population. Within West Yorkshire, South Yorkshire and the Kingston upon Hull area the life expectancy for both men and women was lower than the England average. Whereas in North Yorkshire the life expectancy was higher than the England average for both men and women.

Our inspection team

Our inspection team was led by:

Chair: Darren Mochrie

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team of 24 people included CQC inspectors, inspection managers, national professional advisor, pharmacy inspectors, inspection planners and a variety of specialists. The team of specialists comprised of

Detailed findings

paramedics, emergency medical technicians, operational managers, patient transport service managers, emergency operation centre managers and operations directors.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience Team including the Hazardous Area Response Team
- NHS 111 service

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the ambulance service. These included the clinical commissioning groups (CCGs), NHS Improvement, NHS England, and the local Healthwatch organisations. We talked with patients and staff from the trust and from a range of acute services who used the service provided by the ambulance trust. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 13-16 September 2016, the NHS 111 service from 10-12 October 2016 and we undertook an unannounced inspection on 6 October 2016.

Facts and data about Yorkshire Ambulance Service NHS Trust HQ

The population the trust serves includes:

- South Yorkshire
- North Yorkshire
- Hull & East Yorkshire
- West Yorkshire

Yorkshire Ambulance Service NHS Trust also provides an NHS 111 service to:

- Bassetlaw
- North Lincolnshire.

Activity

- In 2015-26 the trust's A&E service responded to 854,966 urgent and emergency calls.
- The total number of calls for 999 and NHS 111 handled by the trust was 2.6 million calls per year.
- Within PTS in 2015-16 the service made around 1,036,052 journeys transporting patients across Yorkshire and neighbouring counties each year.

Our ratings for this service

Our ratings for this service are:

Detailed findings






	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	Good
Patient transport services	Requires improvement	Good	N/A	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre	Good	N/A	N/A	N/A	Good	Good
Resilience planning	Good	 Outstanding	N/A	N/A	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Notes

Nb. Focused inspections do not look across a whole service; they focus on the areas defined by the

information that triggers the need for the focused inspection. We therefore did not inspect all of the five domains: safe, effective, caring, responsive and well led for each of the core services we inspected.

Emergency and urgent care services

Safe	Good	
Effective	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The emergency and urgent care service as part of Yorkshire Ambulance Service NHS Trust (YAS), employed almost 2000 paramedics, emergency medical technicians (EMT's) and emergency care practitioners (ECP'S) as front line ambulance staff. The service had a fleet of approximately 500 ambulances and rapid response cars which were equipped for emergency response. The service operated from 62 ambulance stations and in addition, used a network of vehicle stand-by points, where staff waited to receive a call. The service also deployed cycle response units in some city centres.

We previously inspected the service in January 2015 and revisited the service from 13 to 17 September 2016 to follow up on identified areas of concern. We also undertook an unannounced inspection on 6 October 2016. We visited 14 ambulance stations across the Yorkshire region including some that had previously been a concern. We visited hospital emergency departments in each part of the region to observe and speak with ambulance staff and with hospital staff about their experience of the ambulance service. We spoke with 100 members of staff including locality managers, clinical supervisors, emergency care practitioners, paramedics, emergency medical technicians and emergency care assistants, medicine management technicians and domestic staff. We observed the care and treatment of approximately 40 patients and spoke with 20 of these patients and their relatives about their experience of the ambulance service. We undertook an inspection of 42 ambulance vehicles both in operation and off-road. We reviewed 20 patient records.

Summary of findings

At our previous inspection in January 2015, the service was rated as Requires Improvement overall. In September 2016 we rated this core service as Good because:

- The trust had put in place processes for risk management and clinical governance of the service. Risks were rated and a review date specified which showed each risk was recently reviewed.
- Positive changes to the executive leadership of the service were recognised and appreciated by staff; the chief executive was seen as approachable.
- The trust was participating in the national trial of the ambulance response project (ARP) which helped the service to dispatch appropriate ambulance resources to patients.
- Outcomes for patients had improved; for example practice to support the return of spontaneous circulation (ROSC) and involvement with regional and national sepsis networks had strengthened the sepsis pathways and improved clinical quality outcomes.
- Staff worked closely with hospital providers of emergency and other providers of services including fire and rescue and community responders to coordinate appropriate pathways of care for patients.
- Staff were able to report incidents readily and learning from the investigation of incidents was shared.

Emergency and urgent care services

- Infection control procedures were followed and ambulance stations and vehicles were clean. A vehicle "make ready" service had been introduced in some stations. There were plans to introduce this across the service.
- Equipment and consumable supplies were readily available and arrangements for disposal of out of date items were in place.
- The workforce plan developed during 2016-17 reflected demand profiles for each area and planned workforce numbers and recruitment were monitored weekly. The workforce plan was communicated and understood by staff which helped to support retention.
- Records contained appropriate and sufficient information about the patient and their condition and were fully maintained and audited.
- Patients with deteriorating conditions were identified promptly and escalated for appropriate treatment. Pathways for assessing and responding to patients who experienced trauma, suffered from chest pain or experienced a suspected stroke were followed.
- Medicines were stored securely and administered safely. Oxygen and analgesic gases were secured securely and were in date. Secure storage for medicines was also maintained in acute hospitals. We saw medicines cabinets were securely locked with access only permissible by ambulance service crews. Controlled medicines were stored in ambulance stations in a locked room within a locked safe and the room alarmed.
- The learning and development of staff was supported. All staff new to the service received thorough induction and training and the service was taking steps to ensure staff received an annual appraisal and clinical supervision. Most staff had completed their mandatory training.
- The culture of the service had improved. Public engagement for the service had developed and included roadshows and community partnership events. Local engagement events had attracted more than 3,000 members of the public. Consultation arrangements with staff included a newly established multi union partnership and the staff forum was embedded.

- Staff knew how to deal with complaints they received, complaints were investigated and we found some evidence that learning was shared with staff. For the 12 months prior to our inspection the service had met agreed due dates in 96% of cases and has achieved an average response time of 21 working days for all services. The service had a standard of 85% for quality audit outcomes, and was achieving 86% at the time of our visit.
- Innovation was encouraged through support for national initiatives and locally based research projects.

However:

- The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.
- The recording of medicines administration contained some discrepancies which were not always identified through audit procedures. At an emergency department we visited, when we checked the stock of controlled medicines, we found the items issued had been audited incorrectly, so that one item was shown incorrectly as in surplus. The service addressed this issue at the time of our visit.
- Records were not always securely stored on ambulance vehicles. We raised this with the trust during our visit and at our unannounced inspection we found that procedures had been changed to protect the security of records.
- It was not always possible for ambulance crews to access secure vehicle seating for children.
- Disposal of clinical waste and sharps was variable in a minority of vehicles and ambulance stations.
- Further work was needed to ensure a target number of staff (at least 85%) received an annual appraisal. The service had in place a recovery plan to achieve 90% appraisal rates by 2017-18.
- Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews.
- Front line staff we spoke with could not articulate the vision and strategy for the service.

Emergency and urgent care services

Are emergency and urgent care services safe?

Good



At our previous inspection in January 2015, safe was rated as Requires Improvement because:

- Cleanliness and infection control practices were poor or inconsistently applied
- Staff were reluctant to report incidents, with no system for feedback or learning from incidents.
- The supply of consumable items and the maintenance of equipment was variable.
- Equipment training for all staff using "track chairs and harness systems" for transporting children had not been consistently introduced.
- The security of medicines in some locations needed to improve and patient records were not always securely stored.
- Mandatory training was not up to date for many staff and did not achieve the trust target for attendance.
- Staff did not have a clear understanding of their roles if a major incident occurred.

In September 2016 we rated safe as Good because:

- Infection control procedures were followed and ambulance stations and vehicles were clean, with consistent clinical audit results for hand hygiene and vehicle cleanliness.
- The workforce plan developed during 2016-17 reflected demand profiles for each area and planned workforce numbers and recruitment were monitored weekly. The workforce plan was communicated and understood by staff which helped to support retention.
- Staff had completed their mandatory training.
- Staff were able to report incidents readily and learning from the investigation of incidents was shared. Staff were encouraged to report incidents and incident reports were welcomed.
- Patient's with deteriorating conditions were identified promptly and escalated for appropriate treatment. Pathways for assessing and responding to patients who experienced trauma, suffered from chest pain or experienced a suspected stroke were followed.

- Medicines including oxygen and analgesic gases were stored securely and administered safely. Controlled medicines were stored in ambulance stations in a locked room within a locked safe and the room alarmed.
- Staff understood their role if a major incident occurred.

However:

- The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.
- The recording of medicines administration contained some discrepancies which were not always identified through audit procedures.
- Records were not always securely stored on ambulance vehicles. We raised this at the time of inspection with the trust and at our unannounced inspection we found that procedures had been changed to protect the security of records.
- It was not always possible for ambulance crews to access secure vehicle seating for children.
- Disposal of clinical waste and sharps was variable in a minority of vehicles and ambulance stations.

Incidents

- Incidents were reported using an electronic system widely used in the NHS. Staff understood how to report incidents which they could do readily using the computer or by telephone direct to the central hub in the emergency operations centre. Staff told us that by reporting incidents this ensured that they were looked at and dealt with. We observed as a member of staff encountered and reported an incident. Staff were encouraged to report incidents and found that incident reports were welcomed.
- The service had two main policies for incident reporting, an incident and serious incident management policy and an investigations and learning policy. Incidents were graded according to severity which was refined further during 2016 to support the appropriate investigation of incidents.
- The service reported incidents monthly to trust managers in an integrated performance report and quarterly to the executive management group and to commissioners. Patient related incidents of moderate severity and above were reported fortnightly to the trust incident review group.

Emergency and urgent care services

- Themes and trends from incidents were reported quarterly to the clinical quality development forum. The trust informed us that subject specific incident reports were reported to the relevant committee or group, for example the health and safety committee or the medicines management group.
- Most staff we spoke with confirmed they received feedback by email after reporting an incident. Learning from the investigation of incidents was also shared. A significant events and lessons learned report was presented in alternate months to the trust quality committee and six-monthly a significant events and lessons learned report was prepared for the board.
- For emergency and urgent care services 2369 incidents were reported between 1 January 2016 and 19 May 2016. The type of incidents included vehicle damage to ambulances or other vehicles, assaults on ambulance crews, injury to patients, equipment faults and drug errors.
- We found that 1149 (48.5%) of incidents were reported as “no harm”, 15% were reported as “near miss” and in 863 incidents (36.4%) harm had been caused. Of the incidents where harm was caused, 64 of these affected patient care, this represented 2.7% of total incidents. Five “catastrophic” incidents occurred, where patients died whilst in the care of the service. The reasons for this included missed diagnosis, failure to follow procedures, delayed dispatch and delayed response.
- We also found that from May 2016 to August 2016 there had been a further 263 incidents reported through the national reporting and learning system (NRLS), of which 90 (34.2%) had been reported as “no harm”. Ten incidents were reported by the service as “severe” and included two incidents of excessive response times which had resulted in patient deaths while in the care of the service.
- Five of these incidents were reported as “internal comprehensive”. These were serious incidents which required investigation; of these, three related to patient deaths due to either excessive response times or the way the call was classified in the call centre. One of the internal comprehensive incidents referred to a delayed response to a road traffic collision which was beyond the control of the service.
- The acute hospital emergency departments we visited during the inspection told us that very few incidents were reported which involved the ambulance service.

- Safety alerts were shared with staff by email and we observed that current safety alerts were displayed on noticeboards in ambulance stations we visited.
- Most qualified ambulance staff that we spoke with were aware of the duty of candour requirements and applied these in their work with patients. The service encouraged staff to be open and honest following a reported incident and appropriate verbal and written apologies were provided for patients.

Mandatory training

- At our previous inspection mandatory training was not up to date for many staff. At this inspection we found staff had completed their mandatory training. The trust provided evidence of the completion of mandatory training, for each staff group, which showed that the actual level of completion of mandatory training exceeded the 85% target, and was 100% completed for many modules and staff groups. Staff we spoke with confirmed that they had completed their mandatory training.
- In the ambulance stations we visited we observed that training rooms and facilities were provided to support staff training. A comprehensive range of training materials were available for staff to use to support their training. Training areas were appropriately equipped.
- Staff received reminders to complete their statutory and mandatory training. Staff completed some elements of their mandatory training on-line. Staff told us they were able to arrange time off shifts to complete mandatory training, some of which was completed in their own time. Clinical supervisors supported staff in arranging to complete their mandatory training.
- Staff had undertaken emergency vehicle (category D1) driver training to enable them to drive under blue light conditions.

Safeguarding

- The service followed a safeguarding policy which included arrangements for children, young people and adults at risk. Procedures were in place for all staff to make a safeguarding referral where concerns were observed. Staff were familiar with safeguarding procedures and were able to provide examples of

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referrals they had made. Staff told us when they had made a referral they received an acknowledgement e-mail to confirm that a safeguarding referral had been received.

- Staff confirmed they could contact the clinical hub for further information about a referral, or to a clinical supervisor for advice in making a referral. The trust confirmed that when ambulance staff encountered safeguarding issues they had priority access to the emergency operations centre, which then contacted the appropriate local emergency safeguarding duty team.
- The service liaised with acute hospital emergency departments, GPs and other out of hour's services to coordinate arrangements for the protection of vulnerable children. There were referral pathways for vulnerable adults to provide extra support.
- When safeguarding risks to children and families were encountered, an internal data flag was triggered to make ambulance staff aware of heightened risks when attending an identified address.
- Staff had undertaken their safeguarding training for children and adults as part of statutory and mandatory training and in addition to induction training. Staff undertook safeguarding children's level one and two and safeguarding adults training every three years.

Cleanliness, infection control and hygiene

- At our previous inspection cleanliness and infection control practices were highlighted as an area of concern. At this inspection we found infection control procedures were followed and the ambulance stations and vehicles we observed were generally clean.
- Procedures for the cleaning of vehicles, medical equipment and ambulance stations had been revised since our previous inspection.
- During the inspection we saw ambulance station premises were visibly clean. Disposable mop heads were used and disposed of correctly. Storage areas were clean and cleaning materials were available and stored appropriately.
- A vehicle "make ready" system to prepare vehicles for use had been introduced as a pilot and was due to be implemented across the service. At some ambulance stations, cleaning staff also cleaned the vehicle exteriors and the cab of the vehicle. Vehicle cleaning was recorded daily.
- Vehicles were scheduled to receive regular deep cleaning at intervals of 35 days. A sticker in the vehicle

gave the date of the last deep clean and when the next one was due. We found this plan was being followed for most vehicles. For example we inspected 24 ambulance vehicles which were available for use or already in use, for the cleanliness of the vehicle. Of these, 20 were visibly clean, including the cab area. Re-usable equipment such as splints, blood pressure cuffs and slide sheets were visibly clean in 21 of the vehicles we inspected.

- Clinical audits for hand hygiene, vehicle cleanliness and ambulance stations were undertaken monthly. The results of audit were reported to the trust board in the integrated performance report. The trust reported that compliance with audit had improved over the previous 12 months, and most areas were achieving 95% compliance.
- Staff training in infection prevention and control was provided at induction and refresher training took place every second year. For 2015-16, 94% of staff had completed this training.
- For the 24 ambulance vehicles we inspected we checked whether there was safe disposal of clinical waste and sharps. We found this was the case for only 15 of the vehicles. Of the remaining nine vehicles, sharps boxes were either full, or open, or not dated and signed. Clinical waste was found in the cab or saloon of the vehicle in some instances.
- We observed that staff followed the trusts bare below the elbow policy. We observed staff were not wearing wrist watches, and that they were wearing gloves when dealing with patients or cleaning the vehicle between patients. Ambulance staff undertook routine cleaning after each patient journey.
- The service policy for infection prevention and control included a requirement for all clinical staff to demonstrate timely and effective hand-washing techniques and carry alcohol gel bottles on their person. Most staff were able to show us their personal issue hand gel. Staff could access hand wash basins within hospital emergency departments and at other services and locations they visited.
- At one ambulance station a full sharps bin was found in the store room and cleaning substances were not secured appropriately. During our previous inspection we found similar issues with sharps disposal and waste management.

Environment and equipment

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- The service operated from 62 ambulance station locations based across each part of the Yorkshire ambulance service region, and we visited 14 of these during our inspection.
- At Scarborough ambulance station there was no fire escape from the first floor. We were informed that estates facilities were subject to a station security assessment so that risks were identified and managed.
- At our previous inspection the supply of consumable items and the maintenance of equipment were variable. At this inspection we found equipment and consumable supplies were readily available and in date. Regular logistics checks of equipment were being undertaken and disposal bins for out of date consumable items were provided in ambulance stations. Faulty equipment was clearly labelled as such and reported to the clinical supervisor. We reviewed a selection of consumable stocks at the ambulance stations we visited and found these were appropriately stored and mainly in date. Any out of date items were identified to staff at the time of the inspection.
- The service had an equipment and vehicle replacement in place and a servicing strategy and a fleet maintenance policy. Standard operating procedures were in place for the service and repair of medical devices and other equipment. Vehicle checks undertaken were set out in a mandatory vehicle checking procedure.
- We found ambulance crews were allocated six minutes at the start of their shift when the emergency operations centre was notified that the vehicle was unavailable to enable the crew to check the vehicle and some key equipment. Not all ambulance crews we spoke with seemed to be aware of this available time. For those staff that did complete checks, they told us there was insufficient time to check all equipment and supplies. After six minutes the emergency operations centre assumed the vehicle was available.
- Information provided by the service showed the ambulance vehicle fleet consisted of 524 vehicles including double crew ambulances and rapid response vehicles. Equipment and consumables required to be carried on ambulance vehicles were specified in the service equipment packing list.
- Damage to vehicle equipment such as stretchers or upholstery were required to be reported and repaired.

We found ambulance crews preferred to use a regular vehicle and expressed a reluctance to release the vehicle for repair in case they were provided with a vehicle in a worse state of repair.

- We inspected 23 ambulance vehicles which were available for use or already in use, for the state of readiness of the vehicle and equipment. Of these 21 of the vehicles, equipment was serviced, portable appliance tested and secure in the vehicle. In addition for 21 of the 23 vehicles, sterile supplies were stored appropriately with packages intact and in date.
- The clinical supervisor described appropriately the actions they took to check vehicles, which included taking the vehicle off road for checks of equipment, informing the supplies department and raising an incident for any concerns.
- We inspected 14 ambulance vehicles which were available for use or already in use, for the state of readiness of the essential emergency equipment. For each vehicle except one, where a defibrillator was not available, checks of equipment had been completed and recorded.
- Of the vehicles we checked, 70% of these were equipped with vehicle harnesses and chairs to support the safe transport of children. However we found not all ambulance staff were aware of how to use the child restraint harnesses. Ambulance staff informed us they would not use equipment they had not been trained to use or where they were unsure of its operation and function.
- An integrated performance report prepared monthly for the board provided evidence of how the board was assured that equipment was maintained and serviced in line with mandatory requirements and manufacturer's recommendations.

Medicines

- Medicines were stored securely and administered safely. At the ambulance stations we visited, we reviewed the storage arrangements for medicines, oxygen and analgesic gases. We found gases were secured securely and were in date. The ambulance service also maintained secure storage for medicines in the acute hospitals we visited. Medicines cabinets were securely locked with access only permissible by ambulance service crews.
- Controlled medicines were stored in ambulance stations in a locked room within a locked safe and the

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room alarmed. The alarm was triggered if the room was accessed without authorisation. Vials of controlled medicines were signed out by qualified ambulance staff and signed back in at the end of each shift by the individual crew member.

- There were arrangements in place with the supplier who made stock deliveries to check stock levels and monitor stocks for expired items. Clinical supervisors also undertook a weekly check of the controlled medicines stocks in hospital emergency departments. At one hospital a clinical supervisor expressed some concern as to the practice of some ambulance crews placing almost out of date medicines into the stock cupboard and taking new items. Clinical supervisors explained how any discrepancies were investigated, with records reviewed to determine whether there had been a loss of stock or whether there was an administrative error. An incident report was raised.
- For 22 ambulance vehicles which included six rapid response vehicles, we checked whether medical gases were stored securely and whether they were in date. For these, medical gases were consistently in date for each of the vehicles and were stored securely for 18 of the vehicles we inspected.
- We inspected 10 ambulance vehicles which were carrying controlled medicines and were available for use or already in use. We checked that controlled medicines were stored securely in a safe or equivalent, whether the safe was secured to the vehicle, and whether the controlled medicines were in date. We also reviewed daily stock checks of controlled medicines, and checked the access arrangements for controlled medicines. We found for each ambulance vehicle that controlled medicines were stored and administered as required.
- We inspected 16 ambulance vehicles which were carrying medicines and were available for use or already in use, and found for each vehicle that medicines were stored securely and in date for 14 of the vehicles. For two vehicles, we found one out of date item of medicine in one vehicle and three out of date items in the second vehicle. In another vehicle we found a broken ampoule of medicine in a storage container and we also found a broken ampoule in the storage container in a second vehicle. Ambulance staff raised an incident report for this at the time of the inspection.
- We inspected an ambulance bicycle and found medicine stocks and medical gases were in order.

- The trusts medicines management team visited ambulance stations and hospital emergency departments to replenish medicines stocks and to undertake audits. The control medicines record book may be on a vehicle for several months before being recalled for audit. We found the recording of medicines administration contained some discrepancies which were not always identified through audit procedures. At an emergency department we visited, when we checked the stock of controlled medicines, we found the items issued had been audited incorrectly, so that one item was shown incorrectly as in surplus. The trust addressed this issue at the time of our visit.

Records

- We found records were fully maintained and audited. Records contained appropriate and sufficient information about the patient and their condition. We reviewed 20 patient record forms for accuracy and completeness and found these were in order, except in one instance where the record was incomplete.
- Completed patient care record (PCR) forms were returned to the ambulance station and stored in a secure storage bin in a locked room for scanning. Records were subsequently scanned and stored securely, with access available to clinical supervisors for audit purposes.
- Confidential waste was disposed of securely at the ambulance station in locked blue bins. Bins were not always secured to the floor or wall of the station. Confidential personal information was not on display in ambulance stations we visited.
- Clinical supervisors completed an audit of five patient records monthly, at each ambulance station which showed a high level of compliance and our own review of records confirmed this.
- During our inspection we saw that records were not always securely stored on ambulance vehicles. We found for 18 ambulance and rapid response vehicles that were operational, five vehicles where patient records and patient's personal information was not kept securely. We observed ambulance crews usually kept patient records in an A3 yellow folder in the cab which included information about patients from the current shift. Ambulance crews usually took the yellow folder

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with them when they arrived at a destination, although in several instances we saw the yellow folder was left unattended in an unlocked cab, which presented a risk of breaching patient confidentiality.

- We raised security of records with the trust during our visit and at our unannounced inspection we found that procedures had been changed to protect the security of records.

Assessing and responding to patient risk

- Patients with deteriorating conditions were identified promptly and escalated for appropriate treatment. Ambulance staff used a recognised clinical decision support system which followed the format of national early warning scores (NEWS). Pathways for assessing and responding to patients who experienced trauma, suffered from chest pain or experienced a suspected stroke were followed. Screening tools for sepsis, spinal injury and fractured neck of femur were used. Rapid arrest teams attended cardiac arrest patients to provide clinical leadership for ambulance staff on scene.
- Ambulance crews were able to contact the emergency operations centre clinical hub for specialist advice in responding to heightened clinical risks to a patient. Ambulance crews also sought advice from their clinical supervisor about patients who presented with heightened risks or unusual conditions. This system had been implemented since our last inspection. We observed an ambulance crew taking this course of action to support their care and treatment of a patient. Requests for additional support were also placed with the emergency operations centre.
- When a patient was being transported in the ambulance, the most senior clinician was located with the patient to continue observations and provide support. The ambulance crew notified ahead to the receiving emergency department if the patient was deteriorating.
- The service used an internal data flagging process where heightened risks were identified to patients or ambulance staff. Safety information could be accessed by ambulance crew to support their attendance at an identified location.
- The service had in place a frequent caller team that identified patients who called 999 for mental health or urgent health care needs. If a patient demonstrated violent or aggressive behaviour, ambulance crew could request the police to accompany the patient during the

journey in the ambulance, and on arrival at the hospital. However, at one emergency department we visited ambulance staff told us the police did not always provide appropriate support in these circumstances, which increased the risk of harm to the patient and to crew.

Staffing

- The service provided details of its workforce in terms of planned and actual numbers of staff employed in each part of the Yorkshire area. Paramedic staff numbers were 5% below planned levels in north and east Yorkshire, but almost 5% over establishment in South Yorkshire. Similar variations were reflected in other areas and staff groups.
- A strategic workforce planning group was established during 2015. Workforce numbers were based on a recognised modelling approach supported by an external organisation. The workforce plan developed during 2016-17 reflected demand profiles for each area. Recruitment events included some which were aimed at recruiting people from black and minority ethnic backgrounds. The service had also introduced two emergency ambulance technician grades.
- Planned workforce numbers and recruitment were monitored weekly and reported through the monthly service transformation programme board and the trust executive. We found the workforce plan was communicated and understood by staff which helped to support retention.
- Staff rotas were arranged up to six weeks in advance for an 11 week period. Staff start times were staggered to 7:00, 8:00 and 9:00 to provide cover for meal breaks and lessen the impact of shift changes. Staff told us they felt the meal break policy worked well in areas where shifts could be staggered. For example for a 07:00 to 19:00 shift, the meal break window started at 11:30. If the meal break had not commenced by 13:30 then at the completion of the current call, the crew returned to the ambulance station for their break. At the time of our visit staff were being consulted about significant changes to the rota.
- Overall, the service operated with close to planned establishment levels, with the exception of clinical supervisor vacancies. We received information that in

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one area the skill mix of staff grades was not well balanced to provide safe crews for ambulance vehicles. However, we did not find this reflected in the deployment of ambulance crews during our visit.

- Staff sickness was close to the England average for the trust overall, and we found sickness was significantly lower in some areas. Service managers explained this was achieved by actively managing sickness with occupational health support for staff during periods of sickness. Staff expressed appreciation of the way the service supported them during periods of sickness absence, and in arranging a phased return to work.

Anticipated resource and capacity risks

- The service managed foreseeable risks through its operational governance and risk management processes. The demand management plan for the service provided the operational approach in situations of excessive call volume or reduction in staff numbers, where the supply of ambulance service resources was insufficient to meet the requirements of patients.
- The service responded to sudden and unexpected changes in demand for urgent and emergency services by deploying clinical supervisors in operational roles, for example as crew for rapid response vehicles. Other senior operational staff, including locality managers, may be deployed in responding to these situations.
- In seasonal or inclement weather, 4X4 (four wheel drive) vehicles were utilised. These vehicles were requested through the fleet management team. During periods of peak winter demand, the clinical support hub included personnel from mental health and social care settings to provide specialist advice for ambulance staff.
- We were informed that business continuity plans were in place to respond to loss of facilities or infrastructure or disruption to hospitals receiving patients which were coordinated through the regional operational centre and available 24 hours a day, seven days a week.

Response to major incidents

- Staff understood their role in the event of a major incident. Any member of staff could call a major incident. Where the incident had the potential for extensive casualties the situation was assessed at the scene by a bronze commander. The Yorkshire Ambulance Service Hazardous Area Response Team (HART) were involved in the event of a major incident.

HART was part of the NHS response to major emergencies which included flooding, public transport incidents, pandemic flu and chemical, biological, radiological or nuclear (CBRN) incidents.

- The service provided evidence of its participation in emergency services planning and rehearsals during 2015. The resource escalation action plan (REAP) coordinated through the national ambulance resilience unit linked the ambulance service with national arrangements to manage operational pressures. The service supported integration with escalation arrangements for the wider NHS. REAP level triggers were reviewed on at least a weekly basis to reassess the impact of potential challenges to the operation of the ambulance service.
- Ambulance staff were offered counselling after a major incident. A debrief was also held to discuss the incident and provide support for staff.
- Locality managers received training for the role of silver commander. Clinical supervisors undertook bronze command training, although one clinical supervisor we spoke with was still to receive this training.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Good



Summary

At our previous inspection in January 2015, effective was rated as Requires Improvement because:

- Many staff had not received appropriate clinical supervision or an annual appraisal.
- The service was not meeting national emergency response time targets for responding to life threatening conditions.

In September 2016 we rated effective as Good because:

- The service supported the learning and development of staff. All staff new to the service received thorough induction and training and the service was taking steps

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to ensure staff received an annual appraisal and clinical supervision. Clinical supervision had become more widely practiced in the service since our previous inspection.

- The trust was participating in the national trial of the ambulance response project (ARP) which helped the service to dispatch appropriate ambulance resources to patients who were very unwell, for example those that had suffered a cardiac arrest.
- Outcomes for patients had improved; for example practice to support the return of spontaneous circulation (ROSC) and involvement with regional and national sepsis networks which had strengthened sepsis pathways and improved clinical quality outcomes.
- Staff worked closely with hospital providers and other providers of services including fire and rescue and community responders to coordinate appropriate pathways of care for patients.
- Patient care and treatment followed evidence based guidance and recognised best practice standards.
- Patients' pain was assessed and controlled promptly.
- Staff understood how consent and capacity issues affected the care of patients and patient's consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act 2005 were followed.

However:

- Further work was needed to ensure a target number of staff (at least 85%) received an annual appraisal. The service had in place a recovery plan to achieve 90% appraisal rates by 2017-18.

Evidence-based care and treatment

- Patient care and treatment followed evidence based guidance and recognised best practice standards.
- The service followed national guidelines including the National Institute for Health and Care Excellence (NICE) guidance and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. The JRCALC guidance for 2016 was being distributed to staff during our visit, which replaced the 2013 guidance. Staff continued to use the 2013 guidance and were awaiting email confirmation to commence using the 2016 guidance. Ambulance staff used the JRCALC pocket book which accompanied them during their shift.
- The service followed local policies and procedures for acute care pathways with guidance specific to the

region. Guidance for ambulance staff to follow was included in the alternative pathways resource pack. For example, information for ambulance practitioners included pre-hospital early warning score, referral for acute ST-segment elevation myocardial infarction (STEMI), stroke pathways, maternity care pathways and tools for major trauma triage. Guidance included screening tools for sepsis, spinal injury and fractured neck of femur.

- Each staff member had information on how to care for patients with sepsis. We observed posters about the care of patients with sepsis in the ambulance stations we visited.
- Patient group directions were followed, for example for the use of controlled medicines not included in JRCALC guidance.
- For section 136 patients, the service used a quick reference guide which included mental health pathways to support the patient experiencing mental health illness being conveyed in line with appropriate professional guidance.
- The service reviewed compliance with national guidance using baseline assessment tools, for example for NICE guidelines. Action was taken to ensure compliance with recommendations. We observed examples of local audit activity, for example reviews of records and medicines administration, which was undertaken by clinical supervisors.

Assessment and planning of care

- Protocols were in place for patients who had experienced a stroke or a heart attack. Ambulance staff also followed protocols for assessing and responding to patients involved in trauma incidents. The service conveyed patients directly to the most appropriate hospital for treatment following major trauma, or for conveyance to maternity, paediatric or other specialist units. Ambulance staff were able to describe correctly destination hospitals and other units for patients from a major incident or patients with specific conditions such as STEMI.
- Ambulance crews were alerted by email, at team briefings with clinical supervisors and by notices in ambulance stations if the directory of services was updated. Enhanced clinical advice and support was available to ambulance crews through the clinical hub 24 hours a day, seven days a week. Ambulance staff also contacted their clinical supervisor for advice.

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- Patients experiencing a mental health crisis were supported. The service had in place a frequent caller team that identified patients who call 999 whether for mental health or urgent health care needs. Ambulance crews were alerted to the needs of these patients. If appropriate the service implemented a management plan specifically for the patient, which may also form part of a multiagency care plan.
- The service undertook a review of identified frequent callers between April 2014 and March 2015 which found that 65% of patients had a known mental health condition which in turn contributed to the volume of calls made.
- The service informed us it was developing a mental health strategy. The service has set up a mental health improvement group to align mental health developments across the service. We were informed that mental health was a key area of improvement for the trust.
- The service informed us that across the Yorkshire region it had an arrangement in place with the police and mental health services to support patients detained by the police under Section 136 of the Mental Health Act. Local arrangements were in place for supporting children and young people detained by the police under Section 136 of the Mental Health Act, with mental health nurses employed by the ambulance service.

Response times

- From April 2016 the trust was participating in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources to patients who were very unwell, for example those that had suffered a cardiac arrest. Yorkshire ambulance service was one of three ambulance services nationally to participate in the clinical coding trial, with evidence of performance monitored by NHS England and the national NHS England ARP Group to assess the impact on patients of both quality and performance. The aim of the trial was to enable the most appropriate clinical response to each 999 call. The trial aimed to test a new evidence-based set of clinical codes that better describe the patient's problem and what response/resource was required.
- Incoming emergency calls were allocated to a category which determined the response, which was nationally agreed. For the ARP, Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious conditions that may require rapid assessment, urgent on-scene intervention or urgent transport. Green calls requiring a response within 60 minutes, were for urgent responses to patients situations which were not immediately life-threatening that needed transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management.
- A second stage trial was due to be undertaken by the trust between October and December 2016 to further refine the clinical code set.
- Prior to participating in ARP from April 2016, the service reported its Red 1, Red 2 and Red 19 performance against national benchmarking indicators. Performance for Red was below the 75% target at 71.1% for May 2016, and 71.6% year to date. For April 2016, Red 1 performance was 69.7% against the national target of 75% (ranking seventh of 11 ambulance services nationally). Red 2 performance was 74.2% against the national target of 75% (ranking third of 10 ambulance services nationally). Red 19 performance was 95.7% against the national target of 95% (ranking second of 10 ambulance services nationally).
- The service integrated performance report for May 2016 showed demand and performance information for the ARP trial which included reporting on how long it took to reach patients in what is known as the tail of performance, the time to reach patients in the 50th, 75th, 95th and 99th percentiles.
- The performance for Red calls had improved for ARP as compared to previous Red 1 calls before the introduction of ARP. For example for 95% of patients seen in eight minutes for Red 1 calls performance was 14 minutes and 5 seconds, while under ARP performance was 13 minutes and 57 seconds. The performance for Amber (within 19 minutes) ranged from 11:11 to 12:59 minutes for the 50th Percentile.
- For June 2016, the third month of the ARP, Red performance was 68% and 70% year to date, against the national target of 75%. The three participating trusts shared performance data weekly and monthly via the national ARP delivery Group.

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- Ambulance crews we spoke with said the ARP helped in the response to very unwell patients categorised as Red. Patients categorised as Amber had a longer waiting time for a response. Crews were aware of the need to monitor closely the appropriateness of response for these patients. Staff we spoke with in hospital emergency departments said the ambulance service response to patients with life threatening conditions was prompt and appropriate.
- The trust participated in a range of national audits of ambulance services. Example of audits included; emergency response in 8 minutes, Red 2 emergency response within 8 minutes, Category 'A' ambulance response in 19 minutes, calls resolved without transport, and re-contact rates following face-to-face treatment at scene.

Pain relief

- Patients' pain was assessed and controlled promptly. Pain relief was administered according to JRCALC guidance, or patient group directions.
- The patient's need for pain relief was included in the assessment of the patient's condition. We observed that ambulance crews asked the patient about their pain score and as they received pain relief from ambulance crew. Actions taken to provide the patient with pain relief were recorded. Clinical supervisors confirmed that patients should have a pain score recorded before and after each intervention.
- Ambulance staff confirmed to us that the patient's pain levels were checked repeatedly throughout the treatment, although we did not observe patients to confirm this. At the hospital emergency department, pain levels and what medication the patient had received were included in the handover.

Patient outcomes

- Clinical quality indicators for patients who may have a cardiac arrest or stroke emergency showed that clinical quality outcomes had improved. Indicators included outcomes from cardiac arrest, return of spontaneous circulation (ROSC), outcomes from cardiac arrest: survival to discharge, and outcomes from ST-Elevation myocardial infarction (STEMI care).
- Outcomes for patients had improved for the return of spontaneous circulation (ROSC). At our previous inspection we reported that the trust was one of the worse performing ambulance trusts at 23% for patients

who had had a cardiac arrest returning to spontaneous circulation (ROSC) at the time of arrival at hospital. For this inspection, the service's cardiac arrest survival rates were ranked first in England for June 2016. Return of spontaneous circulation after an out of hospital cardiac arrest (Utstein guidelines) was 85.7% in June 2016, which ranked first nationally. Survival to discharge from hospital after an out of hospital cardiac arrest (Utstein) was 61.5% in June 2016, which also ranked first nationally.

- We found audits informed the quality governance and clinical quality strategy for the service which supported improved outcomes for patients who had suffered a cardiac arrest.
- The service was involved with the development of sepsis pathways nationally and supported the development of a regional network for sepsis to improve outcomes from the care of patients with sepsis.
- From April 2016 the service commenced a local review of mortality and morbidity, supported by local audit linked to the trust's commissioning for quality and innovation (CQUIN) targets.

Competent staff

- At our previous inspection many staff had not received appropriate clinical supervision or an annual appraisal. At this inspection we found the service was taking steps to ensure staff received an annual appraisal and clinical supervision.
- Appraisal rates were from 60% to 87% against a target of 90% which represented a significant improvement on the appraisal rates we reported at our previous inspection. The service had in place a recovery plan to achieve 90% appraisal rates by 2017-18. Staff we spoke with had received their appraisal in the previous 12 months.
- Most staff also told us they felt the appraisal process had improved, but a small number of staff felt there was little point to them. Staff received their appraisal during dedicated work time and the conversation with their manager or a clinical supervisor was meaningful for most staff and supported their development. Some staff expressed frustration about the arrangement of their appraisal and for a small number of staff their appraisal was cancelled at short notice, without explanation.

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- The workforce strategy supported the learning and development of staff. All staff new to the service received induction and training. Existing staff were also supported to develop their career pathways through the training programme.
- To support retention of paramedic staff, the workforce strategy included development of roles for advanced, specialist and consultant paramedics. Three years following their registration, some paramedic staff could transition to a band 6 role.
- Staff training needs were supported and we received several examples of training courses staff attended to develop their clinical skills and competence. Emergency care assistants were supported to become registered paramedics. Staff expressed to us their appreciation of these development opportunities.
- Staff received clinical supervision both formally and informally. Clinical supervisors delivered a programme of observation and clinical supervision as part of their role. Staff could also obtain advice from the clinical hub. Clinical supervision had become more widely available in the service since our previous inspection, but arrangements for clinical supervision needed to become further embedded. Staff felt mentorship could be used more effectively to support the development of staff.
- Before the inspection we received information about the lack of development opportunities and driver training for some members of qualified staff. However, this was not corroborated during our visit. Ambulance staff received driver training to support the development of their driving skills. The "YAS 24-7" e-learning resource was accessible by all staff.

Coordination with other providers

- The service collaborated in regional urgent and emergency care groups in support of the health economy across the Yorkshire region. The service worked with commissioners to implement the joint strategic commissioning board which included the commissioning of emergency services. The service told us the joint board enabled a dialogue with all commissioners about the strategic development of the service. The service also worked with other trusts to develop the northern ambulance alliance, as well as with other blue light services to support joint service developments.
- The ambulance service participated with the fire and rescue service and other partners in the health economy

to provide a rapid response for falls patients twenty four hours a day seven days a week. The service provided the initial assessment and response for calls when a patient had suffered a fall.

- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. We were informed there were 23 fire service emergency first responder schemes in operation across the Yorkshire region and there were more than 300 community first responder schemes which worked closely with the ambulance service. A fire response car was being developed jointly with the fire service for use particularly in rural areas and had been implemented in some areas.
- The service supported more than 200 community defibrillators which were available for use by members of the public. We observed that the locations used for this equipment included the exterior walls of ambulance stations.

Multidisciplinary working

- Staff worked closely with hospital providers of emergency and other providers of services to coordinate appropriate pathways of care for patients. We visited six hospital emergency departments where we observed the handover of patients by ambulance staff. Handovers were structured and comprehensive. Hospital staff spoke positively of the role of ambulance staff and of their relationship with them. Hospital managers could contact ambulance service clinical supervisors at short notice to provide support.
- At one hospital we visited however, we found handovers could take up to two hours. In order to reduce heightened risks associated with the deteriorating patient, the ambulance service had declined requests from the hospital for ambulance staff to supervise a cohort of patients in the emergency department.
- The ambulance service had subsequently taken practical steps with the trust to reduce the waiting time for ambulance staff. The hospital deployed an ambulance queue nurse which improved communication between the hospital and ambulance service and provided an early warning of patient arrival and to support escalation within the hospital. A further triage of patients may be used to support their diversion to alternative pathways including GPs and community based services.

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- At another hospital, delays had been significantly reduced by the hospital increasing emergency department staffing levels. An ambulance assessment bay was accessed by ambulance crews as a treatment and handover area which support patient privacy.
- At a third hospital, an exception report for ambulance turnaround times was prepared monthly for review by a joint task and finish group of hospital and ambulance staff and including social care and commissioners. The group met monthly to identify and reduce avoidable causes of delay. Actions were agreed and followed up, which included exploring diversional pathways. This initiative had already resulted in improved ambulance turnaround performance.
- Ambulance service managers met at least six weekly with their hospital emergency department counterparts where the response to ambulance vehicle delays and the local escalation plan were discussed. In response to excessive ambulance vehicle waiting times, the ambulance service sent a clinical supervisor to coordinate the situation and provide support for ambulance staff.
- The service worked with residential and nursing homes to identify where patients who were unwell required transport to hospital and where care and treatment could be provided by an alternative healthcare practitioner, so that unnecessary hospital admissions were reduced.
- Referral pathways were in place with community services in some areas, for example the community nursing service, to reduce the transport of patients to hospital.

Access to information

- Ambulance staff received a “Staff update” newsletter and we observed the current issues of the staff update were available in ambulance stations we visited. We also observed ‘YAS TV’ in ambulance stations. Staff told us the information displayed on YAS TV had recently been refreshed. Information for ambulance crew included updates for the national ambulance response programme and other performance information. Incident reporting for adverse incidents, risk, harm, and other priority information was displayed. Staff expressed appreciation of the newsletters which they said were helpful to them.
- A mobile data system widely used in the ambulance service was fitted in all operational emergency vehicles.

Live real time information was refreshed continuously from the emergency operations centre in the ambulance vehicle to provide and confirm current operational instructions for the ambulance crew. For example, the system provided automatic vehicle location information. We observed ambulance crews as they used this system in their vehicles.

- In conjunction with the ambulance service, hospital emergency departments receiving patients in transit used a nationally recognised monitoring system which indicated the number of ambulances on route. The system was used by ambulance staff to register the patient’s arrival at the hospital. The monitoring system displayed information about ambulance patients in progress at the hospital with the time ambulance crews were engaged at the hospital. The information about ambulances in transit was used to manage pressure points in the system.
- The service had a system in place to identify patients with complex needs. A data flagging protocol to record special notes was used for patients with identified needs. We were informed the system was compliant with national guidelines and recommendations.
- We observed that printed and hardback copies of ambulance service specific literature including clinical reference books were available in ambulance stations for staff use. We also observed clinical updates and safety alerts and notices of current events in the region were displayed on staff notice boards.
- Ambulance staff also received operational updates by email, for example, information about road closures. The service had a dedicated email for questions and answers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had in place a policy for consent to examination or treatment. Staff understood how consent and capacity issues affected the care of patients and patient’s consent to care and treatment was documented in their records. We observed ambulance staff in their interaction with patients and saw that verbal and written consent was requested as appropriate.
- Reference prompt cards were used by staff to confirm NHS England guidance about the Mental Capacity Act. The reference cards provided guidance, prompts, flow

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charts and contact numbers as to capacity assessments, making best interest decisions, and deprivation of liberty safeguards. The clinical hub service desk was also available to provide advice for staff.

- Staff we spoke with understood their responsibilities as to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. We observed posters in ambulance stations displayed guidance about DNACPR. Staff confirmed they understood and followed the DNACPR guidance.
- The requirements of the Mental Capacity Act 2005 were followed. Staff told us they had received training in the requirements of the Mental Capacity Act within the previous 12 months as part of their mandatory training and we reviewed evidence which confirmed this. Staff also received information about the Mental Capacity Act in the clinical update.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Good



Summary

At our previous inspection in January 2015, responsive was rated as Requires Improvement because:

- Dedicated equipment was not consistently available to support the needs and maintain the dignity of some groups of patients, particularly bariatric patients.
- Information on how to communicate with patients for whom English was not their first language was not routinely available to staff.
- There was no evidence of learning from complaints and staff received minimal feedback about the investigation of complaints.

In September 2016 we rated responsive as Good because:

- Patients with a learning disability, patients living with dementia, and bariatric patients were supported to use emergency ambulance services. Four specialist bariatric response vehicles were deployed across the Yorkshire ambulance service area.
- Patients with different cultural needs were taken account of in the planning and delivery of services and

actions were taken to address inequalities. The service informed us that qualified interpreters were available on-line. Ambulance service managers met the providers of the translation service monthly to monitor and review the responsiveness of the service.

- The needs of the local population influenced the planning and delivery of emergency ambulance services across the Yorkshire region.
- Patients needing care and treatment for their mental health needs were supported.
- Staff knew how to deal with complaints they received, complaints were investigated and we found some evidence that learning was shared with staff. For the 12 months prior to our inspection the service had met agreed due dates in 96% of cases and has achieved an average response time of 21 working days for all services. The service had a standard of 85% for quality audit outcomes, and was achieving 86% at the time of our visit.

However:

- Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews.

Service planning and delivery to meet the needs of local people

- The needs of the local population influenced the planning and delivery of emergency ambulance services across the Yorkshire region. The service worked closely with commissioners to ensure that ambulance services were delivered as required by commissioners. Regular meetings were held with lead commissioners to discuss activity and service requirements.
- Since the 2015 inspection, a transformation programme had commenced which brought together actions taken following CQC's inspection with other work programmes including those mandated by NHS England. In conjunction with other organisations, the service was undertaking an assessment of the likely future needs of the region for emergency ambulance services. This included elements of capacity and demand analysis, resource management and information management for performance improvement. The project used internal sources of information which included patient feedback, complaints and lessons from the investigation of incidents. It also took account of the

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impact of growth in demand, seasonal variations, financial constraints on the service, and challenges in recruiting qualified staff. The objective of the programme was to ensure emergency services were sustainable in the future.

- The service was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.
- The service had plans in place to replace its oldest ambulance stations with 18 hubs forming a hub and spoke arrangement of locations over a period of several years, with four of these planned to be operational in the next five years. We visited the Manor Mill site which was the first of these hubs to be operational. The ambulance stations at Bentley and Doncaster were due to be replaced by a second hub.
- In York city centre, ambulance staff used response bicycles which were provided by and maintained by an independent local organisation. The bicycle enabled rapid access to be achieved in the most congested areas of the city.

Meeting people's individual needs

- Patients with different cultural needs were taken account of in the planning and delivery of services and actions were taken to address inequalities. Shortly before our inspection, the service had been in consultation with people with a learning disability, people living with dementia, and those with bariatric needs. A new standard operating procedure was put in place before our inspection.
- There were four specialist bariatric response vehicles which were deployed across the Yorkshire ambulance service area. Patients needing care and treatment for their mental health needs were supported.
- We inspected 22 ambulance vehicles which were available for use or already in use, to check whether aids or equipment to assist communication with patients such as picture charts were available for use in the

vehicle. Of these, five vehicles had a multi lingual phrase book or similar aid. For some other vehicles, we found ambulance staff carried a phrase book or other communication aid which was a personal issue and not retained in the vehicle. Staff told us they contacted the translation and interpreter service when this was needed to communicate with patients whose first language was not English.

- The service informed us that the most frequently used languages other than English were Slovak, Polish, Romanian, Czech, Arabic, Hungarian, Russian, Urdu and Punjabi. A qualified interpreter was available on-line, usually within 90 seconds. Ambulance service managers met the providers of the translation service monthly to monitor and review the responsiveness of the service.
- We observed a vehicle used for the transfer of bariatric equipment and ambulance vehicles fitted with bariatric stretchers. We found the issue of equipment for obese patients was the subject of consultation with staff. For some types of vehicles, staff expressed concern as to the limited room for manoeuvring equipment for bariatric patients. Staff also expressed concern as to the limited availability of staff trained to use bariatric equipment. The service was in the process of addressing these concerns by extending access to bariatric equipment and the provision of replacement vehicles carrying stretchers and tail lifts for moving and handling bariatric patients. For bariatric patients known to the service, their needs were assessed and a care plan was prepared which reflected moving and handling risks. We found specialised equipment to support bariatric patients needed to be made more widely available and accessible to emergency ambulance crews.
- Ambulance staff had received equality and diversity training which included consideration of the needs of different faiths, including the provision of chaperones to meet their diverse needs.
- Ambulance staff received awareness training in supporting patients living with dementia. The needs of these patients could be identified for staff using a data flagging system. Staff could be nominated as "Dementia Friends." The service procured ambulance vehicles with a dementia-friendly specification and these were identified with a dementia-friendly sticker in the vehicle.
- The special needs of patients with learning disabilities and physical disabilities could also be identified for staff using the data flagging system. Patients with physical

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disabilities were assessed using a complex manual handling risk assessment form and high risk patients had their addresses flagged to support a specialist response.

- The service employed a “YAS expert patient” who worked with patients with physical disabilities including wheelchair users.
- Patients who used key safe systems for contact in emergencies were flagged on the system to allow rapid access to their home if needed.
- Ambulance staff had received training in conflict resolution and de-escalation, and were aware of the steps they needed to take if a patient was violent or threatening violence. The police were contacted where there were risks to public safety.
- The service worked with commissioners to support patients with long term conditions, which included following existing care plans for the patient.

Access and flow

- The ambulance service reported and monitored handover delays at hospital emergency departments across the Yorkshire region. The main causes of delays were attributed to a lack of assessment cubicles (in 20-30% of instances); a lack of hospital beds for admission (in 40 to 50% of instances) and clinical staff availability (in 30- 40% of instances). Staff we spoke with in hospital emergency departments said the ambulance service response to patients with life threatening conditions was prompt and appropriate.
- Unnecessary journeys to hospital were reduced through the service’s participation in the national trial of the ambulance response programme (ARP) which helped the service to dispatch appropriate ambulance resources. Incoming emergency calls were allocated to a category which determined the response. Ambulance crews we spoke with said ARP helped in the response to very unwell patients categorised as Red. Patients categorised as Amber waited up to one hour, and this also included responses to seriously unwell patients. Crews were aware of the need to monitor closely the appropriateness of response for these patients. Benchmarking information between the two triage systems and between the three participating trusts was shared on a daily, weekly and monthly basis with the trial sites.

- Each call to the emergency services was assessed using a dedicated prioritisation system as part of the ARP. Red calls, requiring a response within eight minutes, were for time critical responses to patients experiencing a life-threatening episode and requiring immediate intervention or resuscitation. Amber calls, requiring a response within 19 minutes, were for responses to patients with potentially serious conditions that may require rapid assessment, urgent on-scene intervention or urgent transport.
- Patients who received an ambulance response were assessed in person by qualified ambulance staff. Ambulance staff used a recognised clinical decision support system. The decision support system followed the format of national early warning scores (NEWS) and assessment guidance to provide a safe alternative to emergency department admission for the patient.
- Green calls requiring a response within 60 minutes, were for urgent responses to patients situations which were not immediately life-threatening that needed transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management. Incidents assigned a Green code were passed to the clinical hub for more detailed triage and clinical assessment. Clinical staff in the hub clinically assessed patients and decided on a response appropriate to the patient’s needs. The response may include despatching an ambulance, referral to a GP, referral to out of hours primary care services, other urgent care pathways, or community care services

Learning from complaints and concerns

- A policy for managing compliments, comments, concerns and complaints was in place. The service informed us that the trust board had responsibility for ensuring a system was in place for managing complaints and that monitoring of themes and trends and learning of lessons was embedded in governance systems. Key performance indicators for compliments, comments, concerns and complaints were included in the monthly board integrated performance report.
- The service aimed to respond to complaints within an average of 25 working days. The service was mandated to meet the due dates agreed with complainants for emergency and urgent care services in 85% of instances.

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For the 12 months prior to our inspection the service had met agreed due dates in 96% of cases and has achieved an average response time of 21 working days for all services.

- The incident review group met fortnightly and reviewed complaints graded red or amber. The group directed the investigation of complaints. The quality committee reviewed the handling of complaints and compliments every second month to identify themes and trends and received an annual report of complaints. The clinical quality development forum received a quarterly lessons learned report highlighting trends and themes and identified actions. The trust board received an annual quality, risk and safety report which included complaints management. The quality accounts described changes made as a result of complaints.
- Staff knew how to deal with complaints they received. We inspected 22 ambulance vehicles and spoke with crew about the use of patient information or leaflets and how patients were informed about raising a complaint or providing feedback about the ambulance service. Ambulance staff informed us that they attempted to deal with any adverse comments from patients directly and patients were also directed to the trust website for information about how to raise a complaint. Five vehicles had information leaflets about complaints and feedback leaflets for patients to complete. In some vehicles, a sticker about how to complain was displayed on the inside of the vehicle.
- Complaints were investigated and we found some evidence that learning was shared with staff. During the investigation of a complaint, we were informed that representatives of the service may meet with the complainant. Staff told us that complaints were discussed in team meetings. Where a complaint related to an identified member of staff, managers engaged with the member of staff to provide feedback and support as appropriate. The newsletter shared with staff contained some material about learning from complaints.
- Reports containing information about complaints and compliments were prepared monthly for each geographical area and shared with locality managers. A manager from the quality and risk team attended locality management team meetings to discuss themes and trends.
- Locality managers received details of complaints which provided an overview of complaints within their area.

- Locality managers provided feedback to relevant staff. The head of operations received details of compliments received. Information about concerns, compliments, comments and complaints was shared with clinical supervisors to support review with the staff involved.
- During 2015 a monthly “Safety update” was introduced which summarised learning from various sources to share within the trust. We found the safety update was well received by staff. The quality and safety team reviewed information from the safety update with other sources of learning such as clinical case reviews to identify trust wide learning.
 - Learning was shared across management groups through reports to the relevant committees and groups and cascaded to staff within local teams. The use of internal staff bulletins was also used to share learning.
 - The service used escalation rates to measure complainant satisfaction with the investigation of complaints. The service reported that in the previous 12 months, the percentage of concerns and complaints reopened due to dissatisfaction with the initial response was 1.5%. The quality of complaint handling was monitored through case file audit. The service had a standard of 85% for quality audit outcomes, and was achieving 86% at the time of our visit.

Are emergency and urgent care services well-led?

Good



Summary

At our previous inspection in January 2015, well-led was rated as Requires Improvement because:

- The trust did not have in place robust governance processes to manage risks or to ensure clinical governance.
- The culture of the service reflected that many staff were unhappy and did not feel listened to or valued.
- Front line staff were not clear about, or engaged with the trust’s vision and strategy for the emergency ambulance service.
- There was a lack of consultation with frontline staff

In September 2016 we rated well-led as Good because:

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- The trust had put in place processes for risk management and clinical governance of the service. Risks were rated and a review date specified which showed each risk was recently reviewed.
- Positive changes to the executive leadership of the service were recognised and appreciated by staff, for example the chief executive was seen as approachable.
- The culture of the emergency ambulance service had improved and staff commented to us favourably about this.
- Consultation arrangements with staff had improved, including a newly established multi union partnership and the staff forum which had become more embedded.
- Public engagement included roadshows and community partnership events.
- Innovation was encouraged through support for national initiatives and locally based research projects.

However:

- Front line staff we spoke with could not articulate the vision and strategy for the service.

Vision and strategy for this service

- The operational plan for 2016-17 defined the vision for the service as “Providing world class care for the local communities we serve.” Linked to the vision was the mission, defined as “Your Ambulance Service, Saving lives, caring for you.” We observed that this information was displayed in ambulance stations.
- The vision and mission were delivered through five strategic objectives, which defined the key priorities, risks and milestones for the ambulance service. A linked integrated business plan for the five years 2014-15 to 2018-19 provided an overview of operational plans for services, including urgent and emergency care. These documents were available through the staff intranet.
- Some managers and staff felt that senior managers and the executive had been clear in setting out the vision and strategy for the ambulance service and were able to describe some aspects of it. However, most ambulance staff we spoke with could not articulate the vision and strategy for the service. Service managers were unable to provide a clear rationale of steps they had taken to engage staff with the vision and strategy. Most staff had the view that the vision and strategy did not directly affect them.

Governance, risk management and quality measurement

- At our previous inspection the service did not have in place robust governance processes to manage risks or to ensure clinical governance. At this inspection the service had put in place processes for risk management and clinical governance of the service. Following our previous inspection the service had undertaken a review of the “well-led” committee structure during 2015 and a review of executive and senior management portfolios in 2015-16.
- The risk management strategy aligned key corporate risks with strategic objectives and was reviewed annually by the executive. The risk and assurance group provided oversight of potential risks to the service identified in the risk register.
- We reviewed the risk register for the service which included current strategic and operational risks for urgent and emergency care. The register described the controls in place to manage the identified risks and gaps in these control mechanisms were also identified. Risks were rated and a review date specified which showed each risk was recently reviewed.
- A clinical governance group with executive representation met monthly and meetings were recorded. Clinical governance risks were discussed and actions taken were recorded and monitored. The clinical quality development forum also met on a monthly basis. A locality manager’s meeting was held monthly; meetings were recorded and actions reviewed and closed when completed. Actions included escalation of key risks and monitoring of local performance.
- An integrated performance report was prepared monthly which included key facts and figures for the service, workforce scorecards, and demand and performance statistics, including a graphical presentation of daily performance for emergency and urgent care. Progress against the strategic objectives was assessed on an exception basis using red-amber-green ratings. Quality indicator results were compared with national benchmarks.
- An audit committee reported to the trust board which provided an oversight of local and national audits undertaken for urgent and emergency care.

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- An operational telephone conference was held twice daily which was joined by locality managers and clinical supervisors. We were unable to attend this meeting during the inspection.

Leadership of service

- The management structure for emergency and urgent care had been revised since our previous inspection. An executive director of operations and an associate director of locality operations had been appointed. Three locality directors (band 8c) representing west, north and east and south localities reported to the associate director of operations. There were seven locality managers (band 7) in each of three localities, who reported with a head of operations to the locality directors. Clinical supervisors (band 7) reported to locality managers and paramedic and non-qualified ambulance staff reported to clinical supervisors.
- Changes to the executive leadership were recognised as positive by staff. The chief executive was seen as approachable by most staff. Aspects of the restructure which involved local operational managers were in progress during our visit. Some managers directly involved in these changes had found them challenging in implementation but they told us they felt the organisation was now well placed to take staff forward. The ability to influence and manage change was seen by some operational staff as requiring development.
- Locality managers felt well supported by the locality directors. Staff we spoke with expressed their appreciation of the support they received from locality managers and clinical supervisors. They told us they found advice and support was available from their line managers and the clinical supervisors. Some staff said they would appreciate more accompanied journeys from their clinical supervisor.

Culture within the service

- At our previous inspection the culture of the service reflected that many staff were unhappy and did not feel listened to or valued. Since the inspection the trust had undertaken a cultural audit of the service in consultation with staff.
- At this inspection we found the culture of the emergency ambulance service had improved and staff commented to us favourably about this. Staff told us management was more open and when decisions were made managers provided a rationale for the decision.

- For most staff, the service was a place where staff wanted to come to work and staff told us that they enjoyed their role.
- Staff welfare was provided and support networks were in place. Although staff recognised there could be significant work pressure involved, most staff supported each other.
- However, we received information from three members of staff which indicated they had not felt supported during investigations of practice or job role changes. Some staff felt the organisation could do more to consider for their work life balance.

Public engagement

- Following our previous inspection the service engaged with health overview and scrutiny committees of local authorities within the Yorkshire region. We found public engagement for the service had developed and included roadshows and community partnership events. Local engagement events had attracted more than 3,000 members of the public.
- People could provide feedback about the ambulance service by telephone, email, by accessing the trust website or by completing a feedback form. Patients could also give feedback to ambulance staff or volunteers in person. We were informed that staff were encouraged to respond to feedback immediately where possible.
- Yorkshire ambulance service scored 100% in the 'See and Treat' survey compared to the 94% England average in July 2016. The 'See and Treat' survey was information provided by patients in relation to different aspects of their care and treatment they had been given.
- The service had introduced a programme of community engagement events across Yorkshire to obtain feedback about services. Partnerships and engagement with communities were supported through YAS roadshows held during 2016. For example, a cardiopulmonary resuscitation (CPR) roadshow was held in Scarborough in August 2016. First aid training sessions had been provided for over 50 local community groups free of charge. The service also engaged with local parish councils to consult about particular issues affecting the service, for example following flooding.
- The service consulted a return of spontaneous circulation (ROSC) feedback group for information about the experience of patients who had suffered a cardiac arrest.

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- We saw that many letters of compliment were received for the public and a selection of these were displayed in ambulance stations we visited.
- Members of the public attended public board meetings.

Staff engagement

- At our previous inspection we found there was a lack of consultation with frontline staff. Following the inspection we were informed that extensive consultation was undertaken with staff. At this inspection we found that consultation arrangements with staff had improved, including a newly established multi union partnership agreement. The service regularly met with unions represented in the service through an operational manager and staff side representation group. There was staff side membership of the transformation board.
- The service had developed a number of areas of staff engagement since our previous visit. The staff forum had become more embedded since our previous inspection and was viewed positively by staff. The service used social media to engage with staff and provided feedback from adverse events and safety roadshows. Examples of areas for which staff opinion was sought ahead of key decisions being taken included replacement of vehicles and equipment and the introduction of the vehicle preparation service.
- The service participated in the NHS staff survey for 2015. We saw 40.6% of the trust's staff responded, compared with a national average of 35.5%. Areas for development identified from the survey included senior management communication with staff, staff feeling able to contribute to improvements at work, and support from immediate managers. The service had an action plan in place to respond to the findings of the survey.
- The service engaged with ambulance staff through regular team meetings, although some staff said consultation was often in the form of being told what would happen rather than being asked what they would like to happen. A minority of staff expressed frustration about not being really involved in a discussion.

Innovation, improvement and sustainability

- The service had started the role of consultant paramedics for urgent and emergency care and introduced two posts to provide focussed clinical leadership for the emergency service. The rapid arrest team provided clinical leadership in the response to

cardiac arrest patients, with the objective of improving the success rate in the return of spontaneous circulation (ROSC). A clinical supervisor attended the scene of a cardiac arrest. Staff commented that the service needed to be extended to more rural areas.






- The restart a heart team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation. The service had undertaken school visits which were featured on regional TV.
- The service received national recognition for its clinical leadership in the development of the West Yorkshire urgent care vanguard. The West Yorkshire urgent and emergency care network planned to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services. The project expected to commence in February 2017 with a three to four year implementation. The objective was improved coordination of services and reduced pressure on emergency departments and in turn on ambulance services.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. More than 300 community first responder schemes worked closely with the ambulance service. The service held community first responders awards in May 2014 and this was repeated, with a two-year cycle, in May 2016.
- The service supported 670 public access defibrillators across the Yorkshire region which were available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages. Ambulance staff were encouraged to report the use of a public access defibrillator so that the patient outcome could be followed up. In the event of a discharge there was an opportunity for staff to meet the patient and their family.
- Members of ambulance staff had won national and regional awards in the last two years, for example the Queens Ambulance medal and the Yorkshire Evening Post awards. The YAS team was highly commended in the category for "Emergency Response Worker of the Year."
- Internal service awards were used to recognise staff achievement. The service held "We care awards" for staff in June 2015 and this was repeated in June 2016. Locality director awards were given to ambulance staff

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for distinctive achievement in survival to discharge. Surviving patients were invited to be present when these awards were given to staff. One member of staff who had been involved in 12 successful resuscitation attempts had a special award.

- Members of ambulance staff could apply to be awarded resources to support local research projects which supported care and treatment in out of hospital settings, for example to support the management of sepsis patients.

Patient transport services (PTS)

Safe	Requires improvement	
Effective	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Yorkshire Ambulance Service NHS Trust Patient Transport Service (PTS) is one of the largest ambulance providers of non-emergency transport in the United Kingdom. It provides transport for people who are unable to use public or other transport due to their medical condition and includes:

- Patients attending hospital outpatient clinics
- Patients being admitted to or discharged from hospital wards
- Patients attending appointments for treatments for example chemotherapy or renal dialysis.

The non-emergency PTS provide support to patients and their carers. The service had 415 vehicles of varying size and capabilities across Yorkshire and Humber. These vehicles were based at 48 locations across five localities covering North Yorkshire and Craven, South Yorkshire, Hull and East Riding, and West Yorkshire. The PTsteam was made up of 692 whole time equivalent (wte) staff who undertook 1,036,052 patient journeys in 2015 – 2016.

There were two PTS communication and control centres; the main one in Wakefield and a smaller one in Willerby. These centres use information technology to support patient needs from initial booking through to transportation. Patient transport services operate seven days a week and covered four dedicated areas of reservations, planning, dispatch and training.

The PTS was supported by 18 on-site Patient Reception Centres (PRCs) and liaison officers within hospitals across the localities. Staff in PRCs coordinated patient transport and were a point of contact for staff in the local acute hospital trusts.

Each locality had a management team responsible for the running of daily operations. All communications staff received training on the in-house electronic system 'Cleric', which facilitated bookings, allocation and tracking. They also received training in call handling and customer care.

The PTS road crews used Personal Digital Assistants (PDAs) which gave them patient information and journey notes. The PDAs also captured data on performance and journey times.

During our inspection we visited each of the five localities by visiting 14 ambulance stations, two control rooms/ communication centres, two PRCs and six hospitals. We spoke with 23 patients and their families/carers, 55 staff which included PTS crew, volunteer drivers, call centre operations staff, maintenance staff, cleaning staff and PTS managers. We also spoke with 23 hospital staff whose patients used the service and checked 38 PTS vehicles.

Prior to the inspection we reviewed a range of information from and about the service.

Patient transport services (PTS)

Summary of findings

We undertook a comprehensive inspection of the Yorkshire Ambulance Service (YAS) in January 2015. At this time, we rated Patient Transport Services as Requiring Improvement in the domains of safe, effective, responsive and well-led. We rated the caring domain as Good.

We carried out a focused follow-up inspection on this visit and looked at the four domains which had required improvement. On this inspection, we found the Patient Transport Services (PTS) had made some improvements in a number of areas from the last inspection, such as mandatory training compliance rates. However, there were still notable improvements required in other areas such as vehicle safety, staff guidance and supervision and leadership of the service. There were inconsistencies in the standards across all of the areas and a general lack of pride regarding the cleanliness of the vehicles. Therefore we have rated the service overall as Requiring Improvement. This is because:

- There had been some improvements to incident reporting and there were also some systems in place to monitor risks. However, there was a lack of robust processes and management oversight to ensure staff had learned from incidents or complaints.
- There were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks.
- There had been some improvements in the maintenance and cleaning of vehicles and the replenishment of equipment vehicles. However, there was inconsistency in what was stored on vehicles and where it was stored. Storage of some equipment was not safe and posed a risk to patients. There were also unsafe vehicles in use and fault reporting was not robust.
- In some localities we found vehicle security to be poor which was a risk to the service.
- There were systems to monitor quality and performance. There had been some improvements in the service's performance against some of the key

performance indicators. However, concerns remained regarding the performance targets not being met for some renal dialysis patients and within the communications and control centre.

- There continued to be staffing vacancies in the communications and control centre. This had a negative impact on patient experience and other stakeholders contacting the service. This also had an impact on the planning and scheduling of patients' return journeys.
- The business continuity plans for the communication and control centre were not well developed despite actions being identified from a table top exercise in October 2015.

However:

- Most staff told us they felt proud to work for the trust. Patient transport service staff felt their immediate operational managers supported them in their role, although there were some reports of a disconnection between staff and senior managers.
- There were robust plans in place for fluctuations in demand, staffing shortages and for adverse weather conditions.
- The compliance rates for mandatory training and staff appraisals showed a significant improvement from our last inspection.

During the course of our inspection, we saw examples of staff demonstrating a caring and compassionate approach to supporting patients. We observed patients dignity being maintained and patient being treated in a respectful way. We also received some very positive feedback from patients and their carers regarding the PTS staff who demonstrated a real commitment to delivering a good service.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement 

We rated safe as requires improvement because:

- The service did not have a robust system for sharing learning from incidents across all localities.
- There were vehicles which were found to have faulty equipment and fittings in place, which were still in operation and had not been properly reported.
- Some vehicles were visibly clean but the service did not have a robust system to monitor the daily cleanliness of vehicles and staff did not have sufficient time to clean the vehicles thoroughly.
- There were items of equipment stored in some vehicles in a way which posed a risk to patients and staff, such as oxygen cylinders which were not securely fastened.
- Eight parked vehicles we checked were found to be unmanned and unlocked at stations and outside hospitals. This was a risk to the service.
- There was no standardisation regarding the type of equipment to be carried on vehicles. There was no consistency in the amount of equipment and supplies stored on board vehicles and where on the vehicles these should be stored.
- Staff were undertaking excessive manual handling activities due to insufficient training in the use of a particular carry chair and the limitations of the carry chair.

However:

- Most staff were observed to be bare below the elbow and adopted good personal infection prevention and controls measures.
- Staff were confident in using the electronic incident reporting system and were aware of their responsibilities in relation to safeguarding children and vulnerable adults.
- All PTS staff were able to assess, monitor and review risks to patients. A complex patient assessment tool had been implemented and staff followed a clear pathway if a patient became unwell on a planned journey.

Incidents

- Incident reporting was undertaken by all staff using an electronic reporting system. Staff told us they were

confident in using this system. Staff were also able to call a dedicated incident reporting line based at the Wakefield communication and control centre and report an incident as soon as it had occurred. This enabled incident logging in a timely manner and meant staff did not need to return to their base to access the online system.

- Incident training was included in the trusts statutory and mandatory training workbook issued to all staff every two years.
- Senior managers told us they were not always satisfied the electronic system they used selected the appropriate staff to investigate reported incidents. Therefore there was a lack of assurance the appropriate level of scrutiny and investigation had been carried out after an incident had occurred. Senior managers told us there were plans to review the way incidents were assigned. However, at the time of our inspection there was no action plan or timescale for this and this was not on the PTS risk register.
- There were 622 incidents reported from 1 January 2016 to 14 July 2016. The incidents included patient slips, trips and falls, vehicle damage, faulty equipment and aggression shown towards staff by the public.
- Of the incidents reported, 55% were reported as 'no harm'. These included incidents such as equipment faults, patients not at the address to be picked up or patient falls while in the care of the service but who did not sustain an injury.
- In the same time period, 43% of incidents were reported as 'minor'. These included vehicle damage after collision, minor injury to patients while in the care of the service or injury to staff while handling patients.
- A total of 2% of incidents had been reported as 'moderate', which included more significant injuries to patients such as a fractured hip sustained while in the care of the service or other significant injuries to staff.
- Of the 280 incidents which resulted in harm, 54% were recorded as harm to vehicles or equipment, 27% were recorded as harm to staff and 19% were recorded as harm to patients.
- The incident involving a patient sustaining a hip fracture whilst travelling was not reported to the Health and Safety Executive. However, the service did undertake a root cause analysis (RCA) which is a recognised process to understand why an adverse event had happened and

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to identify appropriate learning to minimise the risk of recurrence. This was part of the trust's serious incident investigation process and the operations board decided who carried out the RCA.

- We saw the trust had implemented the requirement of the Duty of Candour in relation to this incident. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The team leader was involved in keeping the family of the patient updated at the time of the incident and immediately afterwards.
- Changes had been made to the PTS patient escort procedure, because of this incident. We saw information about this in some of the stations we visited and some staff were aware of the details of this incident. However, the learning and communication was not consistent and some staff did not mention any changes to practice or procedures since the incident occurring. We did not see any evidence of planned audit to ensure changes to practice or procedures had been made.
- Team leaders told us they would visit staff in stations in more remote areas if there was an important change in policy or procedure. Information following incidents was also placed on staff notice boards in the relevant station. We saw notice boards at stations for staff displaying information, which included clinical alerts, patient safety alerts and operational alerts.
- Senior managers could not give assurances there was a consistent mechanism in place to ensure general safety alerts were cascaded promptly to the appropriate staff. We did not see any plans to address this.
- Some staff told us they received an automated acknowledgement via email when they reported an incident on the electronic reporting system. Not all staff we spoke with could confirm they received an acknowledgement for every incident they reported.
- Taxi drivers who were contracted to transport patients were also expected to report any incidents that occurred during transportation. The taxi driver would contact the control centre to report incidents. We were given an example of when an incident had occurred and the taxi driver had reported to the control centre and appropriate assistance was given to resolve the problem.

- There had been no never events recorded in the service in this period. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Mandatory training

- Mandatory training was provided to staff in the form of a 152 page statutory and mandatory training workbook. This workbook book had been revised since our last inspection. Staff were required to complete this every two years.
- There were also mandatory on line training modules for staff to complete. However, we were told by some team leaders there were problems with staff accessing this training. The reasons for this were staff not having the required skills to use the computer, lack of available computers at stations for staff to use and time constraints.
- The trust's target for mandatory training compliance was 85%. Most staff groups in PTS had achieved compliance above this target with an average of 98% compliance. However, managers in the communications team had not achieved the target with 68% compliance.
- We looked at the statutory and mandatory training workbook provided to staff and found some of the material was written in a way which was difficult to understand. In particular, the section relating to mental health was complex and did not give advice on how to approach a patient displaying mental health symptoms. Staff told us they did not transport mental health patients in PTS and thought this part of the workbook was for staff in emergency services. Some staff told us it was not clear which sections of the workbook were relevant to them.
- Drivers received a comprehensive driving training package when they commenced work with the PTS. This was not updated and driving skills were not reassessed routinely. If a driver had been involved in a number of driving related incidents in a short space of time a reassessment would be required. The team leader would arrange for a reassessment to be taken.

Safeguarding

- The trust had a head of safeguarding post but this was vacant at the time of our inspection.

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- There was a safeguarding policy, which included the procedures for both children and vulnerable adults. These procedures were multi-agency and staff could give examples of when they had made referrals.
- Staff told us they would inform the team leader if they had concerns about a child or a vulnerable adult. However, staff told us they did not always receive feedback after they had made a referral.
- All safeguarding referrals made were recorded on the electronic incident reporting system. We checked the information supplied and found this was the case.
- Safeguarding children and vulnerable adults training was mandatory and records showed 94.4% compliance with this.
- There had been ten safeguarding referrals made to the relevant local authority in the period 1 January 2016 to 14 July 2016 by PTS staff.
- Staff told us they were expected to wash their own uniforms. Some staff said they had not been given specific instructions on how this should be done. However, instructions were in the trust's dress code and uniform policy.
- We noted some staff were not wearing the uniform correctly with the epaulettes missing. We asked team leaders about this. They said it was part of the team leader role to audit staff presentation, including uniform, and speak to staff who were not compliant. We did not see any audit data which included this
- We found a variation in the cleanliness of vehicles we checked. Some were very clean inside and out. However, some were found to have visible dirt on the inside particularly in the driver's area. General vehicle housekeeping standards were poor across all localities. For example, sauce bottles and cutlery in the cab compartment in one vehicle. There was a dirty hand brush in the cab of another vehicle we checked and a 'homemade' umbrella holder made from an empty wipes container in one vehicle, which was very dirty. Other examples included the safeguarding certificate dated 2014/2015 for a member of staff in a vehicle's door pocket and an old NHS issue air freshener dated 2003 in the cab. We also found a 5 litre container of blue liquid with no labelling in the patient seating area. This was not compliant with the Control of Substances Hazardous to Health Regulations (COSHH) 2002.

Cleanliness, infection control and hygiene

- The trust had appointed a lead person responsible for infection prevention and control (IPC). There was a trust wide IPC policy available to staff on the trust's intranet.
- Staff were seen to be compliant with IPC procedures in relation to bare below the elbows and using hand cleansing gel between patient contacts.
- There was sufficient personal protective equipment (PPE) on board the vehicles such as aprons and gloves. We found only one spillage kit in Goole ambulance station for one vehicle. We did not see spillage kits carried on any vehicles we checked. Some staff told us they would use gloves and wipes for spillages of body fluids. Some staff told us there were silicone granules which could be used in situations of spilled body fluids. However, we did not see any granules on the vehicles we checked.
- Patients with a known IPC issue would be scheduled to be last on the vehicle and travel alone. The PDA would remind staff to clean the vehicle after use, if a patient was known to have an active infection status.
- A crew member told us there had been occasions when they had discovered patients were being treated for infectious conditions which staff had not been made aware of by the control room. They were unsure if a subsequent incident log was made to report this which meant this may not have been reported back to the referrer.
- We found waste bags containing waste on five vehicles which had been left overnight in the West Yorkshire locality.
- There were inconsistencies in the way staff maintained vehicle cleanliness across the service. For example, we found cleanliness recording sheets present on some vehicles we checked but not present on others. Some staff we spoke with were not aware of a formal procedure for cleaning the PTS vehicles but other staff were able to explain this.
- The day to day cleaning of the interior of the vehicle was the responsibility of the road crew. Staff told us there was often insufficient time at the start or end of a shift to clean properly. Day to day cleaning of the exterior of the vehicles varied depending on the facilities at the station and the weather conditions. Staff also said time constraints meant cleaning the outside of the vehicle was not seen as a priority.
- A dedicated deep cleaning team had the responsibility of cleaning all the fleet vehicles to a schedule of every 6

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weeks. Vehicles we checked had a sticker in the front windscreen indicating when it was last deep cleaned and when the next deep clean was due. All stickers except one were in date and four vehicles were found not to have a sticker present.

- We spoke with a member of the deep cleaning team in the North Yorkshire and West localities who said the workload was unrealistic. They told us some vehicles due to be deep cleaned that week would not be done due to lack of time and a member of staff being absent from work.
- Team leaders told us that spot checks were carried out in relation to vehicle cleanliness but we were not provided with any completed examples of these, following our request for data.
- Infection prevention and control audits were carried out monthly. These were hand hygiene audits and vehicle audits. In May 2016 compliance was 99 – 100% and in June compliance was 98 – 100%.
- We found most ambulance stations we visited were clean. The station at Huddersfield was not in a good state of repair. There were records kept by cleaning staff which were completed daily.
- Most staff were not on the same vehicle for every shift. Team leaders and service delivery managers told us staff rotated to gain experience using new and old/ large and smaller vehicles, working alone and in pairs to keep their skills updated.

Environment and equipment

- Within PTS, there were 415 vehicles including small solo operator cars, larger solo operator vehicles and large multi operator vehicles, which could carry stretcher patients and electric wheelchairs.
- There were manual handling kitbags present on the vehicles we checked. However, some did not have a contents checklist in them. Staff in West Yorkshire told us they thought a checklist was provided some time ago but they have become lost. Therefore, there was no consistency across the localities or in individual vehicles.
- There were four vehicles in the service based centrally, which had bariatric capacity. There were other vehicles available which could accommodate specific weights and wheelchair sizes. These were booked as required via the control centre.
- We found the security at some of the ambulance stations to be poor. For example at Harrogate station,

there was no gate at the entrance to the station. There was a hole in the fence, which backed onto a private garden. We also observed staff working alone in the garage area with the doors open. This was a risk to staff safety and vehicle security.

- Visitors to the station buildings were directed to a main front door which was locked and accessible via a digital locking system. However, the vehicle garages in most cases were open and could be accessed by members of the public. Most stations had a visitor signing in and out book so staff knew who was in the building.
- Keys to PTS vehicles were not always kept in locked cabinets in some stations and were found to be hanging from open key hooks. The security of the vehicles was compromised as a result of this.
- We found a vehicle left unlocked within the garage area with keys on the dashboard at the Barnsley station. Cleaning staff were in the area but there was potential for the vehicle to be left unattended. We found vehicles were also left unlocked and unattended at a number of the ambulance stations and hospital sites we visited in each of the localities.
- We also found at Harrogate station there were pigeons nesting in the garage roof space above the vehicles which were in for repair and deep cleaning. This posed a health risk to staff and patients as there were droppings on the garage floor which could be transferred into the vehicles on staff's footwear.
- There were overgrown trees and hedges which obscured the lighting of the car park where PTS vehicles were parked at the Harrogate station. At this location, we also found three unlocked vehicles, one of which contained an oxygen cylinder. This was pointed out to a team leader at the time of our inspection. We were informed there was a problem with the vehicle's locking mechanism which was awaiting repair. The oxygen cylinder was to be removed. Staff told us the problem with the external lighting and the pigeons had been reported to managers but staff felt there was some reluctance to undertake the work required due to budget constraints.
- The environment in the communication and control room at Willerby station was very hot and cramped. We visited during very warm weather and the working conditions for staff there were difficult. There was no air conditioning and electrical cables were trailing across the floor.

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- There were pocket masks and ambubags in the first aid bags on most vehicles. One vehicle had three ambubags present, which was excessive.
- The first aid bags we checked on the vehicles varied in their contents and not all contained a laminated checklist of contents. We checked the expiry dates on a selection of a number of bag's contents and found them all to be in date.
- There were fire extinguishers on all the vehicles we checked. They were all full but some were not secured properly in the driver's cab. Staff and team leader told us the maintenance and fleet undertook replacement of the vehicle fire extinguishers.
- Staff told us they reported faults with vehicles and equipment in a fault reporting book, which was present on each vehicle and then informed the team leader. The trust had a policy for fleet maintenance but this was not complete with the appendices relating to PTS vehicle safety checks/inspections being absent.
- We found a number of faults on the vehicles we checked which were not recorded in the fault reporting book on board. For example, at Halifax station we found a vehicle had returned from fleet the day of the inspection following repairs to the tail lift and clutch which had a faulty seat belt fastener. This fault was clearly visible as a repair attempt with surgical tape was evident. There was no record of this fault in the fault reporting book. We checked with a team leader to ensure the seat with the fault had been reported to control and decommissioned as the seat belt could not be fastened. We were told this had not taken place. This meant the seat could have been used by a patient with a seat belt which did not work.
- There were broken fasteners on the overhead storage compartments in a vehicle at the Halifax station. These compartments doors were secured with surgical tape. These faults were not recorded in the fault reporting book.
- At Huddersfield station there were other seat belt fasteners which had surgical tape wrapped around them. These were still working but again we found they had not been reported in the respective fault report books.
- At Barnsley station there was a vehicle with a paper sign on a seat indicating it should not be used. This had not been reported in the fault reporting book and the manager did not know how long it had been broken.
- The trust had a vehicle maintenance policy which was accessible to all staff on the trust intranet. This made it clear the driver of the vehicle was responsible to ensure it was roadworthy. The daily vehicle inspection procedure stated the driver of the vehicle was responsible for ensuring it was in a safe, legal and reliable condition prior to use. Each vehicle had its own daily vehicle check book to be completed and any defects found should be noted and reported in the fault report book. The team leaders would decide if these defects meant the vehicle should be taken off the road.
- There were Standard Operating Procedures (SOPs) for transporting patients with infusion pumps in situ and transporting patient with their own oxygen. We found the SOPs did not give sufficient instruction to staff. For example, there was no instruction to staff about what to do if the infusion cannula came out during transportation.
- We saw in the minutes of the PTS Governance Board meeting in July 2016 information which stated there was work to do with regard to SOPs. For example, there was no SOP for the transportation of patients with artificial feeding tubes. We also saw in minutes reference to the SOP regarding driving on motorways with insufficient guidance to staff, such as the wearing of high visibility jackets, who to call in the event of a breakdown and what to do with the patients on board a broken down vehicle. Managers were aware of this and there was a plan to make additions to the procedures and develop further SOPs to cover these circumstances.
- A train the trainer programme was in place for the use of new equipment. Locality managers were taking the lead in this. Staff told us of the train the trainer programme and a team leader advised us they were undertaking this role although they were the only one in that locality.
- We saw a child booster seat had been used to transport a child to an outpatient's appointment. Staff told us they were able to access child seating when it was needed but this was not stored at every ambulance station. Therefore, staff would need to travel to another station to collect this if required. We also saw child booster seats at a PRC at a local hospital for crews to use if a different vehicle was scheduled to collect a child from out patients.
- A number of vehicles had been subject to configuration checks. There were a number of new vehicles which had had the front middle seat removed as they did not have armrests.

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- Some vehicles had carry chairs on board. These were designed for manoeuvring patients through narrow spaces and on staircases. There were caterpillar tracks which could be fitted to the chairs to assist the staff in moving patients. Staff told us they did not use these, as they were difficult to fit to the chairs and had been informed the type of caterpillar tracks were not suitable to use on carpeted staircases. Some staff told us they had received no training on the use of the caterpillar tracks. The written guidance did not make it clear to staff where and when the tracks could be used. This resulted in staff undertaking excessive manual handling and physically lifting patients in the chairs.
- There was a variation in practice across the localities in the checking of wheelchairs and carry chairs. Some items had stickers on to indicate when they were last serviced but this was not the case in all vehicles. We found most of the wheelchairs on board vehicles in the South Yorkshire locality had sticker indicating when the equipment had been last checked. These stickers were all in date on the vehicles we checked. However, in the Bradford, Calderdale and Kirklees locality wheelchairs on board vehicles had no stickers on. Therefore, staff did not know when these were last checked.
- There were inconsistencies regarding staff health and safety for those based in the control rooms or PRCs and spending long periods at a visual display unit. Some staff told us they had not had a workplace environment assessment but other staff had received an assessment. However, staff were able to access occupational health and equipment to assist them if they experienced any muscular skeletal problems. There was also a physiotherapy help-line available for staff.
- There was a system in place for the replacement of empty cylinders at stations and at hospitals. Staff reported this worked well. At Halifax station there was a lack of appropriate warning signage to indicate oxygen was stored there.
- Staff told us patients who required oxygen during transportation travelled on a double crew vehicle in order for the attendant to observe the patient. We saw there was a standard operating procedure (SOP) for this. Staff also told us only staff who were trained were able to administer oxygen.
- Some patients who managed their own oxygen administration were able to travel on a single crew vehicle. We saw there was a SOP for this situation and staff told us how this was managed.
- There was a SOP for transportation of patients with syringe drivers in place. The palliative care ambulance would be used when possible to transport patients who were at the end of life.

Records

- Patient records were held in an electronic format. However, in one vehicle's glove box at Huddersfield station we found a paper record from 2008 with the details of four patients. We also found in the same vehicle patient's details hand-written on a tissue box in the overhead storage compartment. There were no members of staff to report this to at the station at the time of our inspection.
- Staff rarely handled patient's paper records. All patient information required was stored on the individual staffs' PDA. We were informed the PDA remained open once staff had entered their personal identification number at the start of the shift. Therefore, there was a risk of patient data being accessed if the PDA was mislaid or left in an unlocked and unattended vehicle. However, there were no reported incidents of this occurring. We observed staff carrying their PDA at all times when leaving their vehicles.
- Staff would be made aware via the information on the PDA if a 'do not attempt cardio-pulmonary resuscitation' order (DNACPR) was in place. Staff told us they knew the forms needed to be with the patient. They also knew what to do if there was no form present or if the form was out of date.
- Staff also told us they would inform the receiving care staff of the DNACPR status of the patient.

Medicines

- No medicines were kept on PTS vehicles for patient use.
- Oxygen was carried on some vehicles and was stored in gas cylinders. Staff were trained in the use and administration of oxygen.
- All but one of the oxygen cylinders we checked were in date and contained some oxygen. Vehicles which carried oxygen also had the appropriate masks and tubing available for the administration of oxygen.
- On the vehicles we inspected there was no indication of when the on board oxygen cylinders were last checked.

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- We found written information relating to a complaint on papers which had been left on board a vehicle. These papers contained information about the complaint including the patient and staff member involved. We made the manager aware of this at the time of our inspection.

Assessing and responding to patient risk

- Staff received training on recognising and responding to patients who became ill during their journey. There was a clear escalation plan and an emergency vehicle would be requested to attend if required.
- Staff received basic life support training as part of their statutory and mandatory requirements. Records show 73% compliance was reached against a target of 85%. We were told there was a plan in place to increase this to target levels by the end of December 2016.
- There was no resuscitation equipment kept on board PTS vehicles and there was no reference to PTS in the trust's resuscitation policy. However all staff we spoke with were clear regarding the appropriate care of the deteriorating patient.
- Team leaders carried out risk assessments when patients had particular medical or mobility needs. We saw an example of this where a patient with complex needs was attending a hospital appointment, which involved a long journey from a remote ambulance station. The team leader was in frequent contact with the crew and left the station to meet the crew on the return journey.
- There was a complex risk assessment for those patients with more severe mobility or health problems. This was completed by a team leader and used to ensure the patient had the appropriate crew and equipment for their journey. The complex risk assessment had recently been introduced and had not been evaluated at the time of our inspection.
- Team leaders told us they remained at the station and were available for staff to contact until they knew the last patient had been dropped off.

Staffing

- Information supplied to us from the trust indicated the service had a budget for 726.7 whole time equivalent staff (WTE) and the actual number in post was 692

WTE. Other information showed there were vacancies equating to 20.9 WTE staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.

- The planned and actual staffing levels in most teams for the band 2 and band 3 ambulance care assistants matched. There were three WTE band 2 vacancies in the North locality (23.4%) and 1.5 WTE band 2 vacancies in the South locality (5.28%).
- There were also vacancies for band 4 staff with two WTE vacancies (28.6%) in the South locality.
- The overall staff turnover from April 2015 to July 2016 was 5.2%. This was similar to other services nationally. Senior managers told us exit interviews would take place at a local level when a staff member was leaving the service. This information had not been shared or analysed by the service for themes and trends.
- There were fewer apprentices than budgeted for in each of the four localities. In total there were 30 WTE vacancies for apprentices (36.9%) in July 2016. We asked senior managers about this and a number of new apprentices were about to commence with the service.
- There were seven locality managers (band 7) in PTS. One was responsible for the communications team based in Wakefield. The other six locality managers were based in the five localities with the West localities being split. In each of the localities there was at least one service delivery manager (band 5). These post holders had line management responsibility for the PTS team leaders (band 4). The team leaders managed the frontline ambulance care assistants (band 3 and 2). There were 12 team leaders in West, five in North and South and four in the East team. Each team leader was responsible for between 15 and 25 ambulance care assistants and apprentices. The team leaders were also responsible for the line management of the volunteer car service drivers.
- Staff sickness levels in the service were above the national average of 4% in some staff groups. Call handlers and dispatchers had a sickness level of more than 6%. Ambulance care assistants also had a higher than average sickness level of almost 6%. The West locality had the highest level of sickness at 14% with long-term sickness accounting for 6% of this.

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- The PTS managers told us sickness levels were managed effectively with regular contact with staff, access to occupational health and return to work plans. Some said support from the human resources team was variable.
- The PTS crews worked different shifts with shifts ranging from eight to 12 hours in length. Crews and managers told us the rotas were designed to meet patient demand. Crews worked across all the localities and were also expected to work within other divisions such as accident and emergency when required. A team leader was always on shift for the team to contact if needed.
- Within the PTS control centre a workforce management system was used to plan staffing. This was based on the forecasted demand and the schedule of planned work.
- The PTS staff worked flexibly and covered all shifts. Some staff told us they did not always finish on time and were often asked to undertake another journey towards the end of their shift. They said there was no pressure to accept late in the day work and they could refuse to undertake this.
- The trust's major incident plan included the role of PTS in a major emergency. The service would be stood down in a major incident. This plan was reviewed every two years.
- Staff we spoke with were aware of the major incident procedures and how this may affect PTS if the situation arose. Some staff were able to give examples of working with the local fire and rescue service for renal dialysis patients during the floods in late 2015.
- A business continuity exercise had taken place in October 2015 to test out the service's ability to cope if the communication and control centre at Wakefield was out of action. This exercise identified a number of actions, which had not been undertaken as this situation arose in reality in August 2016. The service was not prepared and there were adverse effects to patient journeys as a result. For example, a 'battle box' had not been set up and staff were not clear what their roles and responsibilities were in this situation due to lack of training and guidance.
- The trust has a demand management plan in place for situations where excessive call volumes or a reduction of staff were experienced in the whole service. This was available to staff on the intranet.

Anticipated resource and capacity risks

- The service had business continuity plans in place for untoward incidents and adverse weather. Team leaders and service delivery managers were able to articulate how this would be managed in liaison with the local hospitals. Patients would be prioritised for transportation with those requiring lifesaving treatments such as chemotherapy and renal dialysis being dealt with first. They were also able to give examples of when this had been implemented during recent floods.
- The service was implementing a major transformational change programme at the time of our inspection which included cost efficiencies, reorganisation and service development. We did not see within these plans an emphasis on patient safety. However, there were clear plans to improve efficiency and patient experience in terms of delays in return journeys.
- The service had introduced NHS 111 new vehicles in the last 12 months and we saw a number of these on our inspection. However, there were a number of ageing vehicles in the fleet used for PTS work. Some of these were in a dilapidated state both inside and out.

Response to major incidents

Are patient transport services effective?

Good



We rated effective as good because:

- The service met the performance targets for patients arriving for their appointment on time and for the transportation of patients receiving renal dialysis treatment in most settings. There was evidence of an improving trend for this particular performance target and a plan for continuing this improvement.
- The voluntary car service was well organised and provided a valuable additional to the PTS resource.
- Staff completed a comprehensive assessment of each patient to ensure the service met their transport requirements.
- There had been improvements in some localities in the communication and liaison with acute hospital trusts.

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This had helped with hospital staff understanding the type of transport that would meet patients' requirements, and a better use of resources. However, this was not consistent across all areas.

- Appraisal rates for staff had improved from our last inspection. However, there was a lack of supervision and individual performance monitoring of ambulance care assistants.

However:

- There was a lack of consistency in providing water for patients in hot weather and on long journeys.
- There was a lack of guidance for staff to follow in relation to responsibilities regarding some aspects of their role.
- The recently introduced auto planning system was not working well and had resulted in inefficiencies due to lack of local knowledge.
- Vehicles were sometimes off road for lengthy periods causing problems with vehicle availability for other bookings.

Evidence-based care and treatment

- The trust followed the National Institute for Health and Care Excellence (NICE) guidance for patients who received renal dialysis treatment.
- Patients with other serious medical conditions such as cancer were prioritised to use the service.
- The trust used the Department of Health's assessment criteria to determine whether a patient was eligible for patient transport. The PTS communication and control staff and hospital-based staff used specific questions to determine the patient's condition, mobility and disability as well as determining access to their home.
- There was an eligibility flow chart and checklist available to staff who made bookings for PTS. However, some PTS staff in the East locality reported hospital staff not always understanding the type of transport the patient required when they made a booking. This sometimes resulted in the wrong type of vehicle or crew being dispatched to the patient.
- Some team leaders had tried to improve the appropriateness of bookings by liaising with the relevant hospital departments or managers to explain the type of vehicles and crews available. For example, the relationship between the PTS team leaders and discharge co-ordinators at York were very good but this

was not consistent across the localities. In Leeds, we were told the level of communication was poor.

However, most hospital staff across all localities told us this had improved since the last inspection.

- Although there was no national guidance in relation to the provision of PTS, the trust had adopted a similar service model to other ambulance services in England. Patient travel was linked to their appointment time and patients were given a set time band for when they might be collected. This was 120 minutes in this service.
- Combined localities performance data shows between September 2015 and August 2016, the percentage of inward patient journeys ensuring patients arrived between zero and 120 minutes prior to their appointment exceeded the target of 82.9% at 86.8%.
- There were variations in performance across the localities with the West locality only just achieving the target for patients arriving for their appointment on time and East and North localities exceeding this target by more than 4%.
- The target set by commissioners had decreased since our last inspection from 93.2% to 82.9%. Overall, performance had improved at 3.1% over target performance at this inspection compared to 0.9% over target performance at our last inspection although the percentage of patients arriving on time for their appointments had decreased from 91.8%.
- This performance data for September 2015 to August 2016 also showed the number of patients collected with 90 minutes after their appointment was 91.8% against a target of 91.7%. This is an improvement on the performance data supplied at our last inspection when 89.1% of patients were collected within 90 minutes of being ready against a target of 91.3%.
- The performance data supplied for August 2016 showed there had been a deterioration in the performance in patients being collected since April 2016. This was particularly the case in the West locality. Senior managers were aware of this and attributed it to the introduction of the change programme and the auto planning system. Overall the performance data showed an improving trend.
- Breaches of the collection and pick up key performance indicators were reported to commissioners and information was used to inform future planning for the service.
- One patient we spoke with who had booked their own transport for chemotherapy treatment said the booking

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process took too long. There had been a long wait to speak to someone at the communications and control centre and had been asked many questions which they did not feel were relevant. Another patient receiving dialysis treatment told us they are reluctant to use the service anymore due to long delays getting home. Many patients told us they rarely receive a call from the control centre to say vehicles were delayed.

Assessment and planning of care

- Patient transport services provided non-emergency transport for patients who attended day hospitals, treatment centres, outpatient's clinics or were admitted as non-emergencies or discharged from hospital wards.
- Staff were given details of patients who had additional needs related to their condition such as mobility issues, oxygen therapy or communication problems. Staff also knew if the patient had a Do Not Attempt Cardio-pulmonary resuscitation (DNACPR) orders in place. This was passed to the crews from the communications and control centre staff who took bookings via the PDAs.
- We saw team leaders were actively involved in assessing patients' transportation needs and planned for the right crew and vehicle to transport the patient. However, the trust's policy on the assessment and conveyance of patients did not include the criteria for PTS creating potential for inconsistency of practice.
- Staff were aware renal patients who were receiving dialysis required collection within 30 minutes of their treatment being completed. Alternative provision such as taxis were used to meet the needs of these patients if this could not be met by PTS.
- Any patients with known mental health problems or dementia would be allocated a two-person crew. Staff told us they would not transport patients who were subject to a section of the mental health act and this would be allocated to an accident and emergency crew.
- Bookings were taken at two communications and control centres. These were taken from GPs, hospitals, care home, patients and their families. The larger of the communications and control centres was at Wakefield where all advance bookings and non-urgent same day bookings were made. Urgent same day bookings were made at Willerby station.

- Staff told us they assessed patients when arriving to collect them on an informal basis. This included looking at the environment, accessibility and the patient's mobility before attempting to transport them.

Nutrition and hydration

- Staff and managers told us food for patients was not kept on vehicles. The staff in the NHS trust hospital units and treatment centres where patients were waiting for PTS would ensure adequate food and drinks were provided.
- In some vehicles we found small cartons of water which were for patient use. These were not present in every vehicle we checked. Some patient journeys were long due to the rural nature of some areas. The weather was very warm with temperatures consistently in excess of 25 degrees Celsius during our inspection. Water for patients was not on the vehicle checklist. Staff told us although water cartons were provided for all stations, there was insufficient for every vehicle.
- We requested information from the provider in relation to the provision of water to patients travelling on the vehicles but there was no guidance available.
- We were informed prior to our inspection some diabetic patients who were attending dialysis in West Yorkshire, were at risk due to missing meal times because of long journey times or long waits. This had occurred as a result of the introduction of Autoplan in the area. The service was working towards reducing journey times and waiting times after treatment.

Patient outcomes

- The PTS undertook 1,036,052 non-emergency journeys from April 2015 to March 2016.
- Monthly performance data was collated and the numbers of journeys was consistent. The trend for 2016 – 2017 was the service experienced less patient journeys than expected. Managers reviewed the data each month to determine themes and trends, particularly in relation to aborted journeys.
- The service was introducing auto planning across localities. A pilot had commenced in West Yorkshire in June this year. The introduction of this system had caused some issues in relation to the service's performance. Senior managers were aware of this and a decision was made to delay the roll out whilst investigating the reasons for the decline in performance.

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- Staff we spoke with felt the auto planning system was not intuitive, relied too heavily on satellite navigation and lacked the local knowledge of drivers. Staff told us sometimes crews were sent longer than necessary distances and patients who lived near to each other were not picked up together or dropped off in the right order. Staff also felt this system was ineffective at scheduling meal breaks due to lack of local geographical knowledge and usual traffic congestion in some areas.
- Some localities telephoned all patients to check they still required the transport. This was to reduce the number of journeys where the patient was no longer requiring an appointment due to choice, illness, cancellation or other reasons.
- There had been changes to communications teams as part of the transformation plan and the auto planning pilot. The team was split into virtual geographical areas but still had the ability to work together as a team to achieve the best for patients.
- Other changes had been introduced such as the inclusion of renal patients within core PTS work in the West locality. There had been a deterioration in performance against key performance indicators (KPIs) whilst these changes had been taking place. Senior managers were aware of this recent change in performance and were investigating the reasons. In the interim other providers such as taxis were being used on an extended basis and there had been some improvements in July and August noted.
- Staff in the communication and control centre had to make decisions regarding patient need against use of resources and target times on a daily basis. For example, a patient awaiting collection after chemotherapy may end up waiting longer if the available vehicle could take more than one patient on a longer journey.
- The target for call handling in the communication and control centres was for 80% of calls to be answered within three minutes. Information supplied showed this target was not achieved with 78.5% of calls answered within three minutes in April 2016, 58.9% in June and in September 2016, it was 71.3%. Staff based within a control centre told us they had been short staffed and it was not possible to achieve this target.
- Staff told us there were sometimes difficulties in vehicles being off road for lengthy periods. Managers were aware there were some issues with the fleet availability and the age of the vehicles in the fleet. The PTS transformation plan had incorporated this and a fleet development group had been set up in March 2016. A SOP was to be developed for vehicles which were off road.
- A number of new vehicles had been added to the PTS fleet and there were plans for more to be commissioned.
- The PTS operated to a different set of quality standards when transporting renal dialysis patients. This was similar to other ambulance PTS services, which recognised the needs of this group of patients. The service was required to drop off patients no more than 30 minutes prior to their scheduled time and collect them again no more than 30 minutes after their treatment was complete. This adheres to NICE guidance which states 'Adults using transport services to attend for dialysis are collected from home within 30 minutes of the allotted time and collected to return home within 30 minutes of finishing dialysis'. However, there were still some patients who waited for more than 30 minutes for transport to arrive to take them home after their treatment was completed.
- We spoke with 11 renal dialysis patients. Overall, they reported the service was better than it was 12 months ago but the most significant improvements had only occurred in the last few weeks. Staff in the dialysis units we visited also felt the service had improved over the last 12 months. However, there were still delays in return journeys back home with some patients being advised of delays of two hours or more.
- There was a voluntary car service (VCS) in operation across the trust. This consisted of approximately 80 drivers who had received two full days of training and used their own cars to transport patients to and from hospital appointments. The drivers were reimbursed for the cost of fuel and wear and tear on their vehicles. The volunteers also had a PDA and wore distinctive polo shirts and identification badges provided by the service, so patients knew who they were.
- The voluntary car drivers were able to return any clinical waste they may have accumulated to a station for disposal.
- Staff told us the VCS was invaluable. This service had not been evaluated but the usage of VCS was monitored and it was expected this would have cost benefits to the PTS overall.
- The service also used taxis to transport some patients. Taxi companies were subject to a service level

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agreement to provide this. Taxis were often used at weekends, particularly for transporting renal patients to and from dialysis. Some patients told us the taxis were not prompt in coming to collect them and did not always ensure they were returned safely into their homes. Staff told us there was no specific guidance regarding the expectations of patient care when dropping patients off at home.

- The performance for return journeys was within 90 minutes of the patients finishing their appointment. Most staff we spoke with felt this was problematic and the service needed to work hard to manage and improve this.

Competent staff

- We found staff had the appropriate skills, knowledge and experience in order to do their job.
- Staff told us they had a good induction when they had commenced work with the service. We spoke with some staff who were new to the service who said they had been prepared well for the role of ambulance care assistant. Other staff said they had been given the opportunity to shadow an experienced member of staff.
- Drivers had been assessed to have specialist driving skills for larger vehicles as part of the induction process. Staff told us they were not reassessed after this training unless they had been involved in a number of incidents. However, the driving licenses of all drivers including volunteers were checked every two years.
- Managers told us a number of staff had been assessed as car drivers only due to health issues. This was part of an occupational health review. This was managed in the localities and there was no evidence of an impact on service delivery.
- Ambulance care assistants had also received first aid training and moving and handling training.
- We saw mixed understanding of the mental capacity act and its purpose. Staff told us this was covered within training they had received but they were not able to explain in any detail their understanding.
- There were no formal arrangements for one to one meetings or supervision sessions between the team leaders and ambulance care assistants, neither was there a formal record of individual staff performance. Team leaders told us they did spend time with their staff on vehicles during a shift when they were needed to fill gaps in the rota.
- Most staff we spoke with had received an annual appraisal. Information supplied to us showed 81.4% of staff had received an appraisal in the service from April this year. This was an improvement from our last inspection where 79% of staff had received an appraisal.
- Some staff said their appraisal had been meaningful and helpful. One team leader told us they expected staff to tell them what additional training they wanted rather than suggest to staff what would be beneficial to them or the service
- Volunteer drivers were provided with a comprehensive induction and training which included a week shadowing another VCS driver. We spoke with a volunteer driver who said they had been fully trained and prepared for the role. There was a dedicated team responsible for the management of these drivers ensuring they had the appropriate checks prior to becoming operational. This included personal references, disclosure and barring (DBS) checks, car insurance and MOT status. The VCS drivers were included in email correspondence to ensure they were up to date with developments and any changes in procedures.
- Team leaders across the area acted as champions and supported staff with general information and advice.
- Call handlers in the communications and control centre received regular supervision from their team leader. However, they told us it was very busy most of the time and had trouble 'catching up' in between calls.
- One member of staff we spoke with felt there was little opportunity to develop from their current role. Other staff said they had been offered opportunities. We spoke with a team leader who had started in the service as an apprentice and had worked in a number of roles prior to being a team leader. A senior member of the management team told us training in relation to 'complex' patients was to be rolled out. This would also include dealing with violent and aggressive patients. We did not see any agreed dates as to when this training would be rolled out.
- The recent restructuring of the service had seen the creation of new job roles. There was a band 4 team leader position and a band 5 service delivery manager position. Staff in these roles told us they lacked direction and understanding regarding their responsibilities. The trust had provided some additional management training in the last 12 months to support

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them with this. We saw the communications staff taking calls and allocating work to the PTS crews. They were confident in what they were doing. Many of the staff had been working for the services for a long time.

Coordination with other providers

- Most staff we spoke with at local NHS trusts reported good working relationships with ambulance care assistants. In some PRCs, we saw ambulance care assistants occasionally worked as co-ordinators, which helped relationships.
- There were sixteen patient reception centres (PRCs) in local acute hospital trusts across the five localities. This was where PTS staff co-ordinated the return journeys for patients who had attended appointments or required discharge from hospital.
- The PTS team was required to work closely with a number of health and social care providers as well as providers in the voluntary sector.
- There were arrangements in place in some acute hospitals for a dedicated discharge team who worked until 8p.m. and at weekends. We were told these teams were often overloaded with work. We were also told they were often delayed due to arriving on wards to find patients' medications were not ready to take home.
- Staff working in the communications team should notify providers if there was a delay in a patient arriving for an appointment or if there was a delay in collecting them. Staff we spoke with in provider units said on most occasions they were made aware by PTS staff if there were delays. They told us they had been contacted if there was a delay to check if it was still appropriate to bring the patient. For example, to check the doctor would still be able to see the patient if attending an outpatient appointment.
- We visited two hospitals in Leeds which utilised the patient transport services. Staff from an outpatient department told us until very recently there had been no engagement with the Yorkshire ambulance service. They also said the ambulance office (PRC) within Leeds General Infirmary had been closed without any notification. Staff felt the only point of contact was the control centre to deal with any daily issues.
- A member of staff from the executive management team told us they acknowledged engagement with hospitals had not been good in some areas. An additional member of the team had been appointed to improve this. We saw evidence of recent meetings with this member of staff and clinical staff within the local hospitals.
- In some hospitals, the relationship between key staff arranging discharges and the PTS team leaders was very good. Staff in one acute hospital in the North and Craven locality knew the team leaders by name and said they responded well if there was an immediate issue to resolve. Another example was the regular monthly meetings with the oncology department at an acute hospital in East Yorkshire.
- Hospital staff also said the service was improving in relation to the collection of patients after their appointments, compared to 12 months ago but there were still lengthy delays on occasions. Patients who had late clinic appointments sometimes had to wait for their transport after the clinic had closed which affected the hospital staff who needed to stay on duty to be with them.
- Whilst we were in the communications and control team at Willerby, we observed two instances of bookings being aborted because of poor communication. Patients had cancelled their hospital appointments but not cancelled their transport. Patients were not aware they needed to do this themselves. This resulted in a crew being a long way from base and therefore unable to undertake another job prior to the end of their shift.
- Information supplied to us showed high numbers of aborted journeys. Between April and September 2016 there were 9,550 aborted journeys. The main reason for this (3784) was due to the patient making their own way. The other two main reasons for journeys being aborted were the patient no longer had an appointment (1,401) and the patient was too ill to travel (1,261).
- Staff in one hospital location told us patients on a specific pathway of care meant they arrived for a scan by emergency ambulance. This had been booked by a GP surgery. The responsibility for the return journey booking was then left to the staff in the ultrasound department which could be a lengthy process and a long wait for the patient.
- Some hospital staff were not making full use of the ambulance portal, which would mean they could look up bookings and dispatched crews for their patients.

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- Hospital staff who were using the online portal system told us it was sometimes frustrating as there were time limits in place for changing and amending bookings. They also said access to the system was sometimes denied.
- Senior managers told us there was a plan to improve the relationship and communication with acute providers and as such, an additional member of staff had been appointed to specifically liaise with providers.
- In times of high demand, PTS worked with other third party providers including voluntary car drivers (VCS) and local taxi firms in order to ensure continuity of service. This was coordinated via the communications and control centre and the locality team leaders.
- There was a dedicated discharge team in PTS to ensure acute hospital providers received a smooth service for patients. These patients were often on the day bookings and an additional team in communications was able to deal with this.
- Following the introduction of auto plan, a renal transport charter had been developed to ensure all stakeholders were clear about each other's roles and responsibilities. This was following complaints made from the British Kidney Foundation about the poor service renal dialysis patients were experiencing in the Leeds area. We spoke with some patients in Leeds and they told us they were still unhappy generally with the service provided. More specifically the time it took to be collected to return home. Some renal dialysis patients told us the delays caused disruption to their lives. Two of these patients told us they tried to make their own arrangements for transport due to the on-going problems. Following these discussions the trust advised dialysis patients were to be prioritised ensuring the NICE guidelines were adhered to.

Multidisciplinary working

- There was evidence of multidisciplinary working between PTS staff and other care providers such as care homes, hospitals and GPs. During our inspection, we saw cooperation between hospital staff, the communication and control centre and staff in the PRCs.
- Some ambulance care assistants and staff in PRCs told us the staff in the communication and control centre lacked the local knowledge of road conditions, geography and specific locations, which resulted in inefficient route planning. This was in relation to auto plan in West Yorkshire. Overall, we observed good relationships between ambulance care assistants and staff in the communication and control centre. This was important in order to promote good team working and effective care for patients.
- We spoke to staff at Leeds General Infirmary who told us the ambulance transport office within the hospital had been closed without any communication to the outpatient's team. Staff explained they had received a memo a couple of days before it closed. The memo gave a telephone number to use for future ambulance bookings. Staff told us there had been no communication from senior managers in the PTS.
- Staff told us they had received training on end of life care and they knew the procedures in relation to Do Not Attempt Cardio Pulmonary Resuscitation orders.
- We were told PTS would not undertake transportation of patients who had been sectioned under the Mental Health Act; the Accident and Emergency teams who had a higher level of training would undertake this work.

Access to information

- Information about patients given at the booking process was available to the PTS staff via the PDA. This included special instructions such as digital keypad entry codes, access issues and relevant medical conditions. Any urgent or additional updates from the communication and control centre were sent to the PDAs throughout the ambulance care assistants shift.
- In some rural areas staff experienced difficulties with network connectivity and communication could be compromised. Most staff told us the radio would work even if the PDAs did not. Staff working in these areas were aware of the places where the PDAs did not work.
- We found one unmanned vehicle unlocked at Northallerton station with the communication radio switched on. We were able to hear the communications and control centre staff. There was a potential for this to be abused as the public were able to access the area where the vehicle was parked.
- Staff told us they liked the introduction of YAS TV – this was a way of staff receiving high level information in the staff room or other areas without having to log onto a computer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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- Consent and the Mental Capacity Act was included as a module in the staff statutory and mandatory training workbook. Compliance for this mandatory training was above the target of 85%.
- The mandatory training workbook did not include any information on the Deprivation of Liberty Safeguards (DoLS), so staff were not aware of the legal aspects of transporting these patients.
- There was no place on the patient booking system to record if a patient was subject to a DoLS authorisation. Staff we spoke with were not familiar with this therefore, they potentially could transport patients who had been subject to a DoLS authorisation or may require some form of permitted restraint to which they could not consent.
- We observed staff talking to patients and gaining verbal consent before a moving and handling task was carried out.
- According to the National Ambulance Service Medical Directors (NASMeD) and Association of Ambulance Chief Executives there was an expectation for ambulance staff only act to restrain people to the same level as that of a member of the public. Ambulance services were not required to provide physical restraint training for their frontline staff.

Are patient transport services responsive to people's needs? (for example, to feedback?)

Requires improvement



We rated responsive as requires improvement because:

- Patient care and treatment was compromised on occasions due to transportation problems. Diabetic patients experienced missed meals.
- Staff were not fully trained to deal with complex patients and were dependant on information provided by the control centre.
- Staff were not able to demonstrate clear understanding of diversity and equality issues.
- Lessons learned following incidents and complaints were not shared consistently with all staff and at management meetings.
- Patients were not provided with sufficient information in relation to making a complaint.

- There was a lack of consistency of equipment on board PTS vehicles across all areas of Yorkshire.

However:

- There were plans to roll out training for all staff regarding 'complex' patients, which included risk assessment training for team leaders.
- Most patients we spoke with told us they had no difficulty contacting the control centres to book appointments.
- Most renal patients we spoke with were satisfied with their service. However some patients were still experiencing delays in the West of Yorkshire due to initial Auto plan problems.

Service planning and delivery to meet the needs of local people

- The PTS primarily operated a Monday to Friday 8.00am to 5.30pm service and had 415 vehicles within its fleet. However, the service also operated outside of these times to provide specific support to patients attending for renal dialysis when needed. There was also a dedicated discharge service which operated into the evenings in some localities. This was included within the main core contract.
- In addition to this PTS provided transport to patients to and from a local day centre on behalf of a local authority. Inter site transfers were also provided under a fixed value agreement for a neighbouring local authority.
- Airedale PTS provided a dedicated discharge team on a Saturday. We did not see any plans to roll this out to other areas.
- There were 2354 cancelled journeys in September 2016. These journeys were cancelled by hospitals. Aborted inward journeys were 2444 for the same period with the highest proportion due to 'no appointment'. A further 1402 were cancelled due to duplicate bookings already in the system. Fifty two of these journeys were cancelled due to a YAS fault. We did not see any action or improvement plans in place to address this. We observed examples of aborted journeys during our inspection where a vehicle and crew had arrived at a patient's home to be informed the hospital appointment had been cancelled by the patient but they had not informed PTS.

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- The PTS also supported acute hospital discharge across the region. Operating times varied across the area, due to the commissioning arrangements. For example, in the East it operated between the hours of midnight to 11.00p.m. and in the North it was 10.00a.m - 8.00p.m.
- The service had recently commenced a pilot in May 2016 using 'auto plan'. This was an automated software planning system to schedule patient journeys. The PTS transported patients based on the time of their appointment and auto plan scheduled journeys to ensure patients were collected and delivered within an agreed window of time. Ambulance crew told us the system switched over to a manual plan after 11a.m which meant staff had to add certain jobs to the system manually. The pilot, which was originally trialled in Leeds, was then rolled out to West Yorkshire. A senior manager told us there had been 'teething problems' such as patients travelling in the vehicles for long periods of time. As a result of this, the ambulance service was currently reviewing the software.
- Some staff in West Yorkshire were unaware of auto plan. Four members of staff told us they felt the new system created 'dead miles' and vehicles often crossed each other creating wasted journeys. 'Dead miles' were journeys completed by the drivers without any patients in the vehicle.

Meeting people's individual needs

- The PTS control centre planned and delivered journeys to take into account the needs of different people. For example, those patients with a specific mobility issue or dementia requiring more than one crew member.
 - Crews were also advised by the control centre staff of vulnerable or complex patients. They provided them with additional data through the PDA system (personal digital device). We saw this in operation during our inspection. Complex patients were those patients who had a specific issue such as dementia, obesity or challenging behaviour.
 - Staff gave us two examples of occasions where the auto plan system was not able to plan the transportation of patients requiring a stretcher effectively. Staff told us they needed to return to a station to remove the stretcher in order to accommodate all other patients on the vehicle. This created 'dead miles' and wasted time for the patients waiting for transportation.
 - Control staff told us in each geographical area had slightly different eligibility criteria for patients using PTS.
- Staff told us this occasionally created confusion due to several patients travelling in the same vehicle from different areas. However, the electronic systems used were programmed to ensure compliance with these criteria.
- Most of the patients we spoke with they found it easy to contact the control centre to book appointments.
 - There was a policy in place for the transportation of bariatric patients and a pathway for the control centre to follow, to ensure the service met the needs of these patients. The PTS had four dedicated bariatric vehicles and had a full inventory of equipment such as hoists and large wheelchairs. We spoke with a senior manager who told us it was unlikely all vehicles would be requested at the same time due to the careful booking and planning of these vehicles. Hospital staff we spoke with knew 48 hours' notice was required if a bariatric patient required transportation.
 - We spoke with a locality manager who told us a risk assessment was completed by a team leader when a booking for a bariatric patient had been requested. Team leaders we spoke with confirmed this.
 - We asked staff if they had received specific training in relation to dementia care. All staff told us this was covered as part of their induction training and refreshed annually through the statutory and mandatory training programme.
 - We saw the service had produced 'life story' books which were aids to staff when supporting a patient with dementia. We saw these books on only nine vehicles, and staff in other stations were not aware of them. We saw a number of these books stacked in the office at one station. We spoke with one member of staff during our unannounced inspection who advised although the station was supplied with these books, there were not enough for every vehicle.
 - Some staff in the West told us their knowledge of diversity and equality came with 'common sense'. Some training had been provided as part of their induction but we could not find any evidence of specific focused training in relation to this.
 - Staff told us they could access interpreter services if required. We saw two examples at the control centre of occasions where interpreting services had been used in PTS.

Access and flow

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- Patients could be referred in a number of different ways depending of the criteria for each area. The contact centre took calls and electronic bookings from GP surgeries and hospitals and patients were able to ring directly to book transport. There were several contact centres to cover each geographical area.
- We spoke with 23 patients who regularly used the patient transport service. Eight patients told us although they were collected in good time for their appointments and treatment, they frequently waiting some considerable time for their transport home. Five patients within a Leeds hospital told us it was not unusual to wait more than two hours or more to be collected to travel home.
- Yorkshire Ambulance Service changed their procedures in May 2016, which meant renal patients travelled with non –renal patients. This commenced in the Leeds area initially and then rolled out to the West Yorkshire area in June 2016. This resulted in large numbers of complaints by patients regarding the time they were waiting to be transported home. Patients wrote to NHS England and their local MPs to advise of the difficulties they were experiencing and the impact it was having on their lives. Senior managers acknowledged the timeliness of transport particularly around the collection of patients. Measures were in place to improve this and there had been written communication with renal patients directly from senior managers in the trust. Discussions were also on-going with the local hospitals in relation to patients being declared ‘ready’ in a timely manner to avoid delays. Yorkshire Ambulance Service had specifically appointed a new member of staff to improve this who commenced in August 2016.
- Seven of the renal patients in the West Yorkshire area we spoke with advised us they had received a written apology from the service in relation to these delays. This letter also advised the service would ensure they arrived no more than 30 minutes before their appointment, and be picked up no later than 45 minutes afterwards.
- In all other localities, most renal patients were satisfied with their service and felt delays traveling home were acceptable as they felt the service was doing its best.
- There were examples when patients care and treatment had been compromised because of problems with PTS. An example included patients who were taken off their dialysis treatment early as the transport had arrived and was unable to collect them later.
- We spoke with three nursing staff working within a local hospital who told us they had recently been advised to inform PTS they were ‘ready for collection’ as soon as patients arrived for treatment. This enabled the patients to be ready for collection during a specific time window. Staff told us previously this had not been allowed which meant long delays for patients as on occasion drivers would arrive at the hospital before patients were ready.
- Most of the hospital staff we spoke with reported there were delays in getting through to the communications and control centre. Hospital staff told us they would ring the control centre up as often as they could to try and find out what time patients would be collected.
- One hospital out patients’ department had installed a separate telephone specifically for calling the PTS communications team. This was due to staff waiting for a long time meaning the telephone to the department was often engaged for other callers.
- Most staff we spoke with told us they had good relationships with the control centre and were not pressured to rush journeys or fit additional jobs in when it was not possible. Where there were issues, staff referred to the ‘manner in which they were spoke with’ by control room staff.
- We spoke with four staff at the communications and contact centre in Wakefield. They all told us they had faced difficulties recently trying to accommodate all of the calls due to staff sickness. On the day we inspected there were two members of the team off sick and staff were extremely busy. We were told the sickness had been a problem for some time and the team felt unsupported.

Learning from complaints and concerns

- There were no information leaflets provided for patients to explain how they could make a complaint. Patients told us they would ring the control centre and speak to one of the hospital staff to ask them to make a complaint on their behalf.
- Most vehicles we saw had information about the patient advice and liaison service in the form of a small poster stuck to the inside of the vehicle.
- There were a total of 108 complaints received by the Yorkshire Ambulance Service between July 2015 and June 2016. The majority of which (94) related to PTS operations staff.

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- During the reporting period of April 2015 to March 2016 41 (64%) of complaints related to delays in taking patients to and from hospital appointments.
- We saw within the written complaints sent to the service, some diabetic patients had missed meals due to these delays and length of time they had spent on the vehicle. Other complaints included patients who had been collected for their appointments as early as 5.00am and had arrived at the clinic to find it had not yet opened. Several patients said they wanted to 'give up dialysis' due to the impact the transport problems was having on their life.
- We were told by a locality manager complaints were discussed during monthly Locality Management Team Meetings. A manager from the Quality and Safety team attended each meeting to identify and discuss themes and trends. We looked at the minutes of these meetings for April 2016 and June 2016 and complaints were not discussed.
- When a complaint was submitted, the locality manager for that area received an alert on the electronic reporting system, which provides them with the details of the complaint. The managers are responsible for investigating the complaints and ensuring appropriate feedback is disseminated to relevant staff.
- All compliments are sent to the Heads of Operations via the electronic reporting system. They were responsible for writing to individual members of staff and congratulating them on the positive feedback. However, not all staff were aware of this practise.
- The trust told us they recognised the importance of sharing learning across the organisation when things have gone wrong, including learning from complaints. In 2015 the Safety Update was introduced which is a monthly bulletin, pulling together learning from across different inputs to share across YAS. This was then triangulated within the Quality & Safety team alongside other inputs such as Clinical Case Reviews (CCRs) to identify trust wide learning. The Safety Update had been well received by staff.
- A senior manager told us learning was shared across management groups through reports to the relevant committees and groups and cascaded to staff within local teams.
- The trust had introduced YAS TV July 2016 with the purpose of sharing learning through the use of videos and information which is cascaded to staff via the TV in stations.
- However, all staff told us no time was allocated to read these bulletins and updates. Staff arrived early before their shift starts or try and find time during their lunch break to read emails. Staff did feel YAS TV was useful although it was not available in all stations.

Are patient transport services well-led?

Requires improvement



We rated well led as requires improvement because:

- The service had developed an operational plan which set out its strategic objectives but staff we spoke with felt they had not been involved in this plan and were unclear about the future direction of the service.
- There was a clear lack of management oversight and lack of ownership of roles and responsibilities.
- Governance systems were not fully embedded throughout the service. Governance management meetings had only recently been introduced.
- There were inconsistencies in the monitoring and oversight of staff performance and adherence to policies and procedures. This meant there were differences across the service in how information was shared following incidents, cleanliness of vehicles, equipment stored on vehicles and learning from complaints.
- Operational staff felt there was a 'disconnect' between executive and senior management and frontline staff.
- New job roles had been created through a process of restructuring services but these post holders and other staff were unclear about their roles and responsibilities. This resulted in inconsistent team leader support and some difficulties for staff in obtaining the support they required.
- Operational staff felt they were not always valued by the organisation.
- There had been a lack of engagement with the some acute hospital trusts resulting in inappropriate vehicles and crews being despatched to patients and an ineffective use of resources.

However:

- Local leadership was good, although team leaders were not available at each station they maintained frequent contact with ambulance care assistants and volunteers through regular telephone calls.

Patient transport services (PTS)

- A transformation programme was in place to develop and create a modern PTS. This involved actively developing strategic alliances and move towards The Yorkshire Ambulance Service becoming the co-ordinator for transport services.

Vision and strategy for this service

- Yorkshire ambulance service had an operational plan which set out its strategic objectives, intentions and goals. The plan identified the key priorities, risks and milestones for the next twelve months. We reviewed the most recent business plan which included a transformation programme covering eight initiatives. This included the implementation of auto plan scheduling (computer route planning), developing the voluntary car service and streamlining reservations. Other priorities included effective sub-contractor management and improvement to fleet availability.
- We also viewed 'Your Ambulance Service' which was an integrated business plan for 2014/15 – 2018/19. The document outlined the ambitions, aspirations and plans for the service as a whole for the next five years. There were a number of initiatives which were central to the strategic priorities. These included an expansion in the number of urgent care clinicians, expanding the existing NHS 111 service and developing care pathways for specialist groups such as frequent callers, mental health patients and palliative care.
- The YAS vision and values were displayed on staff notice boards and staff had access to communications bulletins via emails.
- The trust had installed 'YAS TV' in some of its ambulance stations. The station delivered key messages regarding the whole of the Yorkshire ambulance service and providing staff with information regarding changes and achievements.
- Senior managers were aware of their key pressures and risks but staff within the ambulance stations were not able to explain what the future strategy was for PTS. Staff in most ambulance stations were aware of the auto scheduling for example, but they were not aware of the plans for its roll out and which stations would be affected.
- Several staff told us they did not receive regular updates from senior managers regarding the direction of the service.

- Senior managers met to discuss strategic performance on a monthly basis as part of management meetings and regularly at board level.

Governance, risk management and quality measurement

- YAS had a governance framework, which supported the delivery of the strategy. The service produced an integrated performance report each month which outlined performance, workforce and finance trends and issues. Clinical issues, and complaints leading to the overall quality of care for patients were also addressed within the report.
- The PTS nominated leads from each team measured performance against national benchmarks. The PTS lead director and managing director attended trust board meetings to present this information.
- PTS had recently developed a specific governance management group. This had met for the first time in May 2016. The purpose of the group was to ensure operational practice was consistent across all localities.
- There was a specific team to manage the voluntary car service (VCS). A senior manager told us team leaders acted as champions to these drivers and provided support and information to the drivers as required. We were also told there were open mornings specifically for the volunteer drivers for peer support.
- The service had a risk management procedure and PTS staff were clear about their role and accountability for reporting incidents. However, staff told us they did not always receive information regarding incidents. Sometimes they received a general safety bulletin but there was no discussion and no consistent system to share the learning from incidents with frontline staff across all divisions. The team leaders we spoke with were not aware of the outcome of investigations following incidents. Team leaders told us they would liaise with locality managers when accidents and incidents had occurred but did not always receive feedback once these were logged. Two team leaders we spoke with told us 'there are simply not enough hours in the day'.
- The PTS risk register contained six risks. Two were low risk and four were moderate risk. The moderate risk relating to patient slips, trips and falls had been on the register since 2013 but had been reviewed regularly. The

Patient transport services (PTS)

other moderate risks included the service for renal patients in the two West Yorkshire localities, unplanned accident and emergency operations affecting PTS and the lack of PTS bid resource.

- PTS completed operational risk reports, which were completed by the locality managers. They outlined specific risks to the service. Risks included the loss of technology to communicate to the staff, how transport should be dispatched in the event of a breakdown in the system, financial risk due to tendering and on-going risks of slips, trips and falls.
- The service had a lone working policy, but most staff we spoke with were unaware of any practices or procedures in relation to it. Staff told us they would contact the control centre or try and locate their team leader if they had an issue. There was a system to track vehicles but no system to monitor lone workers such as mechanics and cleaning staff aside from the rota, which identified single crew vehicles.

Leadership of service

- Staff knew who some of the executive team were but none were aware of who the Chief Executive was.
- None of the operational staff we spoke with had seen any members of the executive team during their work. However, the trust told us they had visited as many stations as possible.
- Staff told us they rarely saw the locality managers for their area. Some staff said it was sometimes very difficult to get in touch with a team leader. Two members of staff told us ‘the team leaders didn’t answer their telephones’.
- At one station we visited, crew told us a team leader had not been in place for several months as they had left the trust. A new team leader had been appointed at the time of our inspection and was currently receiving training. Staff at the station told us no one was appointed to cover this post during this time and told us ‘we just manage and get on with it’.
- Staff working within new middle management roles were unclear as to their roles and responsibilities. Team leaders told us they were ‘firefighting’ and were trying to do their best with the time they had.
- There was a lack of consistency across the service in the way staff performance was monitored. There were also inconsistencies in management oversight in checking

adherence to policies and procedures. This had resulted in variations in practice such as cleaning of vehicles, equipment stored on vehicles and learning from complaints and incidents.

- We found staff were receiving training which did not fit their role. For example, the training for PTS staff about mental health included information about various sections of the mental health act. Staff told us patients who were subject to a mental health act section would not be transported on PTS vehicles.
- Morale varied across the stations we visited. Operational staff were concerned about the tendering process for PTS and unsure what the future held for them. Two of the existing services were out to tender at the time of our inspection (Hull and South Yorkshire).
- Staff generally felt detached from the core of the service and the wider organisation. Some staff told us they felt ‘undervalued’ by their managers due to the lack of visible contact and support. Staff felt that senior managers did not understand the pressures that operational staff faced.

Culture within the service

- We observed staff working cooperatively with each other and respecting each other’s roles. Several staff we spoke with had worked for the service for many years and were loyal and flexible. The majority of staff we spoke with enjoyed their job and were proud to work for YAS.
- Guidance was available for staff to raise concerns in the workplace and staff told us they would ring if they had a problem. However, feedback following concerns was not always provided and staff often tried to deal with issues themselves rather than escalate them to managers. A member of staff told us ‘we support each other here’.
- We spoke with staff from one control centre who told us ‘We have been left out on a limb’ and felt ‘forgotten’. All staff here told us they had received no support from their manager and we saw morale was particularly low in this team due to the on-going lack of support. Some staff were concerned about their future as a result of the tendering processes.
- The PTS crews told us general relationships with the control centres were good. Staff said they did not feel pressured during the course of their work and maintained frequent contact with control centre staff during their shift.

Patient transport services (PTS)

- The service promoted a culture of openness and transparency and all staff we spoke with were able to explain the principles of the duty of candour.

Public and staff engagement

- Staff did not feel engaged with the senior management team. PTS held staff forum meetings bi-monthly. However, we did not see evidence of these discussions cascaded to staff. Staff told us ideas were not brought forward at these meetings and were unable to provide any specific examples.
- Noticeboards in ambulance stations displayed general staff memos, safety alerts and education updates. The standard of these noticeboards varied from station and old information was not always removed and replaced with current guidance. In two stations we saw safety notices dated from 2013.
- There was also a locked notice board in most of the stations we visited. These were purely intended to display audit results for the station area. All locked notice boards we saw were up to date.
- PTS crew and control centre staff received most of the communication bulletins via email. However, most staff we spoke with felt there was no time allocated to read this information. Staff checked these messages at the beginning or end of a shift. We also saw staff reading bulletins during meal breaks.
- There were no assurance processes in place to ensure all PTS staff read and understood the information sent to them. Team leaders and senior managers told us it would be checked during the staff appraisal.
- We were told by a senior manager there were no trends identified as a result of the high sickness. We could see muscular skeletal injuries were high but we did not see any actions plans to address this.
- We were told exit interviews were conducted when staff left the service. However, no data was collected to improve service as a result of this and managers could not provide any examples of themes.
- We spoke with a senior manager regarding the high levels of sickness in certain geographical areas. They were fully aware of problematic areas due to sickness numbers however we did not see any action plans in place to address this.
- YAS held its own 'We Care' awards for staff in June 2015 and this was repeated in June 2016.

- A member of staff told us they were invited to a long service award ceremony hosted by YAS. However, they were advised to take annual leave in order to attend the event.
- YAS had worked with representatives of the trust's Critical Friends Network and the 13 Yorkshire Local Involvement Networks to develop a PTS Patient Charter. Launched in September 2011, the Charter set out their responsibilities and commitments to provide a high quality service. It also set out the standards of conduct they requested from their service-users.




Innovation, improvement and sustainability

- A transformation programme had been developed and had recently commenced implementation to create a modern PTS service. A new detailed workforce strategy, and new operating model had been outlined which involved alliances with other providers. This programme included increasing the voluntary car driver workforce, in order to support the delivery model.
- As part of the above transformation programme the service was actively building strategic alliances with appropriate sub-contracting arrangements to provide a total transport solution with YAS as regional coordinator.
- Patient transport services were part of a competitive market. Two of the existing services were out for tender at the time of our inspection.
- A 'Bid Team' had been established with Business Development Directorate to deliver the requirements for these service tenders.
- Yorkshire Ambulance Service had implemented 'auto plan' which is a computer assisted route planning system. This software had been piloted in May 2016 in Leeds. The executive management team felt this pilot was a success. An extension of this pilot was rolled out in June 2016 in West Yorkshire. At the time of inspection the system continued to be tested and refined. We spoke with a member of the executive team who told us there were plans to roll this out further and decisions as to the timescales for this would be made in January 2017.
- We saw in the minutes of the locality managers' meeting arrangements were being made for staff in the control rooms to access the auto plan system to become familiar with it.

Patient transport services (PTS)

- In response to the increasing number of patient slips, trips and falls reported, an additional member of staff had been appointed to take a lead with the aim to improve overall patient safety.
- In response to earlier infection control audit results the service implemented the use of 'service cleaners' at each ambulance station.
- Yorkshire Ambulance Service currently had 50 agreements in place to provide non-emergency transport for primary care trusts and acute trusts across Yorkshire.
- The PTS achieved ISO22301 for business continuity in April 2014. This certified the trust were following international standards to ensure safety, reliability and overall good quality.
- A specific room had been introduced at the Leeds ambulance station for staff undertaking personal development. This would enable staff to have 'private facilities'.
- The trust had a 'Freedom to speak up' campaign and had appointed 'guardians', which enabled staff to send in anonymous questions or concerns about patient or staff safety, with the support of the guardian and receive feedback from the chief executive.

Emergency operations centre

Safe	Good	
Well-led	Good	
Overall	Good	

Information about the service

The Emergency Operations Centre (EOC) received and triaged 999 calls from members of the public as well as other emergency services. It provided advice and dispatched an ambulance service to the scene as appropriate. The EOC also provided assessment and treatment advice to callers who do not need an ambulance response, a service known as “Hear and Treat”. Hear and Treat is telephone advice that callers who do not have serious or life threatening conditions receive from an ambulance service after calling 999. They may receive advice on how to care for themselves or where they might go to receive assistance.

The EOC also managed requests from healthcare professionals to convey people either from the community into hospital or between hospitals. The trust had two Emergency Operations centres (EOCs), one at the trust headquarters at Wakefield and the other in the North Yorkshire area based in York.

The EOC telephony platform was set up so that it performed as one virtual call centre. This meant that whether in York or Wakefield the call handler who was available would deal with the next incoming call regardless of the geographic location of the caller. This had seen call distribution shared equally across both sites and improved call answer times for callers/ patients ringing 999.

The EOC had three core sections: call takers, dispatchers and a clinical support desk. At the Wakefield EOC, there was also a frequent caller section and safeguarding hub. The call handlers were responsible for answering and triaging calls in accordance with clinical need.

Clinicians, including specialists such as paramedics and mental health nurses, staffed the clinical support desk. It supported the call handlers with advice for complex calls and made telephone welfare checks, particularly when there had been a delay in a vehicle arriving on scene. They

also provided advice to emergency responders. The dispatch team was responsible for allocating calls to vehicles in accordance with clinical priority and location of vehicles.

The emergency operations centre received 855,015 urgent and emergency calls in 2015-2016; this was an average of over 2,342 calls per day.

The Yorkshire Ambulance Service (YAS) covered North Yorkshire, South Yorkshire, West Yorkshire, Hull and East Yorkshire covering almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities delivering a service to over five million people. There were 23 acute hospital trusts within this area and 23 Clinical Commissioning Groups (CCGs).

In January and February 2015 CQC carried out an announced comprehensive inspection. For the EOC we rated effective, caring, and responsive domains as good and rated safe and well led as requires improvement. Overall this meant the service was rated as requires improvement. This was because staff did not feel supported or encouraged to report incidents and did not receive feedback from incidents they had reported. Staff were not aware of the trusts vision or strategy for the service and there were mixed views about the leadership and culture; not all risks had been identified on the risk register.

This inspection took place between 13 to 16 September 2016 and was a focused inspection to follow up on the requires improvement in the safe and well led domains from the previous inspection. As part of this inspection, we spoke with 41 staff. This included emergency call dispatchers, emergency medical dispatchers, staff nurses, a mental health nurse, paramedics, administration/clerical support staff, EOC managers and senior managers. We also listened to thirteen 999 emergency calls.

Emergency operations centre

Summary of findings

Overall, the service was rated as good. This was because:

- The emergency operation centre (EOC) used an evidence based clinical triage system to assess patients.
- They had access to a language interpreter service and text relay service for patients with impaired hearing.
- Paramedic and mental health support and advice were available.
- Staff knew how to report safeguarding concerns. Safeguarding referrals could be made 24 hours a day through the clinical hub.
- Staffing levels were scheduled and planned on an electronic system, which took into account previous demand data and forthcoming events.
- Governance processes were in place and there were clear governance structures. Risk registers were reviewed and management were able to describe the current risks to the EOC.
- The culture of the service was open and transparent and staff told us they received good support from their team leaders and duty managers.
- The trust had been involved in a number of initiatives, such as, 'The Blue Light' programme. The aim of the programme was to improve the mental health of staff working in emergency service by having 'Blue Light Champions' to act as support to staff.
- The service was one of the leading organisations in the piloting of the Ambulance Response Programme (ARP) introduced in April 2016. ARP aimed to improve response times to critically ill patients by ensuring an appropriate response to patients first time.
- Incidents were reported, investigated and lessons learnt shared with staff across the organisation. Although the majority of staff received feedback from incidents, there were inconsistencies as some staff had not always received individual feedback. This was also the findings at the previous inspection.

However we also found:

- Not all staff using the evidence based clinical triage system was up to date with basic life support (BLS)

training. Up to date training was a requisite for a licence in the use of the system. Following the inspection the trust wrote and assured CQC that by the 1 December 2016 85% of the EOC staff would have BLS training. They also informed us that they had recently been re-accredited by the International Academy and given centre of excellence status. Training on BLS instructions within the dispatcher role was part of the criteria for re-accreditation.

- Not all nursing staff were up to date with safeguarding training.

Emergency operations centre

Is emergency operations centre safe?

Good



We rated the service as good. This was because,

- Staff knew how to report safeguarding concerns. A safeguarding referral could be made 24 hours a day via the clinical hub.
- Records were securely managed.
- The trust used an evidence based clinical triage system to assess patients.
- Staffing levels were scheduled and planned taking into account previous and forthcoming demand data.
- There were Emergency Call Dispatchers (ECD) shortfalls and staff recruitments were at various stages of training
- Major incident/events plans were in place, which took into account anticipated capacity risks.
- Incidents were reported, investigated and lessons learnt shared with staff across the organisation. Although the majority of staff received feedback from incidents, some staff reported inconsistencies as they had not always received individual feedback.

However we also found,

- Not all staff using the evidence based clinical triage system was up to date with basic life support training. Following the inspection the trust wrote and assured CQC that by the 1 December 2016 85% of the EOC staff would have BLS training.
- Not all nursing staff were up to date with safeguarding training.

Incidents

- An electronic incident reporting system was in place and staff had received training. However, due to the staff needing to be available to fulfil the role of the EOC, the team leaders reported incidents on their behalf. Lessons learnt from incidents were shared with staff across the organisation. Although the majority of staff received feedback from incidents, there were inconsistencies as some staff had not always received individual feedback.
- On the staff 'Safety updates' posters, we saw there were contact details for staff to report incidents 24 hours a day, seven days a week. The information reminded staff they had access to the reporting system for updates on incidents they had reported.

- Between 29 May 2015 and 30 June 2016, there were 309 reported patient safety incidents. The main causes were delayed response, delayed dispatch and delayed back up. Of these, nine incidents were reported as "catastrophic." For example, a patient death resulted. Five had been reported as major; examples included an inadequate clinical response, which resulted in harm to a patient.
- Fourteen incidents were reported as moderate harm; examples included delayed response or dispatch, which may have contributed to harm to patients.
- Twenty-five incidents reported were minor; such as delayed response which may have contributed to harm or death. These included injury to staff or road traffic collisions.
- Eighty-seven incidents were reported as a near miss, where there may have been potential harm to the patient.
- One hundred and sixty nine reported incidents resulted in no harm caused whilst in YAS's care.
- We saw an example of where a serious incident was identified and a Root Cause Analysis (RCA) had taken place to establish the cause of the incident. This allowed staff to identify risks and make appropriate changes to prevent similar incidents from occurring. An action plan with timescales accompanied the RCA.
- Information, including themes from RCA's were shared with staff via operational updates and sent to clinical supervisors to display on the ambulance stations. Although some staff reported they had not always received individual feedback from incidents reported, the majority of staff told us they had.
- YAS investigating managers had received RCA training and were supported during investigations by the Head of Investigations and Learning, who had received and delivered training.
- The trust Incident Review Group (IRG) met fortnightly and considered all incidents rated as moderate or above via the trust risk grading system. IRG was the key forum for ensuring themes and trends were identified. Lesson learnt were shared across teams and appropriate action plans were in place. The Executive Medical Director for the trust chaired the meetings. The group included the Executive Director of Quality, Governance & Performance Assurance, associate directors, clinical leads, as well as managers responsible for the work areas.

Emergency operations centre

- The EOC safety improvement document outlined the plans which were aimed at reducing human factor incidents in the EOC: A patient safety incident group had been set up to discuss incidents and learning for staff. The emphasis of the work in this group was to promote a safety culture. This included staffs acknowledgment of their mistakes, learning as a result and empowering them to take actions to minimise the risk of recurrence.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Operational staff we spoke with, both at York and Wakefield EOC had limited knowledge of the duty of candour. They did understand about being open and honest when something had gone wrong. We were told that it would be the role of senior management to undertake those responsibilities. Three senior managers we spoke with understood the duty of candour and confirmed they carried out as part of their roles.
- We saw three examples of where the duty of candour was applied. This showed the trust was open and transparent with families when things went wrong.

Mandatory training

- Staff could access some areas of mandatory training through the electronic communication system used by the trust.
- Mandatory training targets within the EOC were 85%. We found the compliance levels across the staff groups were above 92% for the staff nurse group and paramedics. The call handler dispatchers and emergency medical dispatchers were all compliant with mandatory training.
- Mandatory training for call handlers/ emergency medical dispatchers included annual fire safety awareness (89%; 214 whole time equivalent (WTE) staff had completed the training), Health risk and safety awareness (94.5%; 226 WTE staff) and Learning Disability Awareness (92%; 221 WTE staff had completed the training).
- Completion of training in the medical assessment and triage system for call handlers was mandatory before they could use the system.

- Staff using the system confirmed they had received training and this included the new Ambulance Response Programme (ARP) training prior to each phase of implementation. Information provided by the trust showed that 100% of staff had completed the training.
- The Wakefield EOC training spreadsheet showed there 23 were staff not up to date with the basic life support training..
- Following the inspection, the trust wrote and assured CQC that by the 1 December 2016 85% of the EOC staff would have BLS training. They also informed us that they had recently been re-accredited by the International Academy and given centre of excellence status. Training on BLS instructions within the dispatcher role was part of the criteria for re-accreditation.

Safeguarding

- Two administrative staff 24 hours a day, 365 days a year staffed the health desk.. Part of their role was to take information from staff across the trust about any safeguarding concerns, for both adults and children. The health desk staff would use the information to complete a safeguarding referral form and then send the referral to the appropriate local authority.
- Staff we spoke with understood how to identify and report safeguarding concerns.
- The EOC safeguarding training compliance target was 85%. The call handlers/emergency dispatchers (240 staff) had achieved 92% compliance for safeguarding adult training, 93% for children's training level one and 85% compliance for levels two.
- Paramedics in EOC had achieved 100% compliance training for safeguarding adults and between 94% - 100% for safeguarding children levels one and two training.
- Staff nurses had achieved 79% compliance for safeguarding adults training and level one children's training. They had achieved 68.7% compliance for safeguarding children level two training. That equated to just over 20% of staff nurses not yet having had the up-dated three yearly training.
- For mental health awareness and capacity training; 91.8% of call handlers/emergency dispatchers and 100% of paramedics had achieved training compliance.

Emergency operations centre

- In relation to whistleblowing, Equality, Diversity and Human Rights: 94.7% of call handlers/emergency dispatchers and 100% of paramedics had achieved training compliance.

Cleanliness, infection control and hygiene

- The trust had an up to date infection prevention and control policy. This was accessible to staff via the intranet.
- All areas within the EOC we visited were visibly clean and tidy.
- We saw hand cleaning, antibacterial gel dispensers were available for use in the different areas of EOC.
- Infection control training for staff was mandatory every two years. The target rate for trust staff was 85%. With the exception of two staff nurses, the training rate achieved was between 94.5% and 100%. This included the training of paramedics, call handlers, emergency medical dispatchers, managers and clerical workers.
- Staff could describe the action they would take if a suspected communicable disease was identified during the triage of a call.
- The clinical hub staff provided information and advice about risks of infection to ambulance crews. Examples included, where the clinical hub had supported ambulance crews during a measles outbreak and when transporting a patient with Tuberculosis Bacillus. The advice they provided included information about cleaning the ambulance following transportation of patients with infectious diseases.
- In the interest of infection control, staff were issued with individual equipment such as headsets for telephones.

Environment and equipment

- We found the EOC at both York and Wakefield was well maintained. Identification badge access was required to enter the buildings and individual rooms.
- Staff had access to appropriate equipment for their work such as headsets, telephone systems and IT systems. Portable electrical Appliance Testing (PAT) had taken place on all relevant equipment.
- Weekly emergency equipment checks took place in conjunction with the police and fire service. Analogue telephones were available to serve as a backup system if the digital telephone system failed. Standalone digital radio sets were available in case of total telephone failure and a paper based recording system.

- Staff had access to work station assessments. Desks could be raised to different levels to facilitate staff to working in either a sitting or standing position to promote workplace health and safety.
- At the Wakefield office, staff sat at set desks to work. A seating plan was used to regularly change where dispatchers would sit. This ensured staff had experience and knowledge of dispatching work to different geographical areas within Yorkshire.

Medicines

- The clinical hub staff had access to medicine databases. They were able to provide support and advice to ambulance crews about medication. For example, advice as to whether it would be safe to give a patient a drug taking into consideration the patient's own medication.
- Ninety two percent of call handlers and emergency dispatchers had received medicines management training as part of their induction.
- Call handling staff were able to transfer a call to a clinical advisor if advice regarding medicines was required.

Records

- Call records and details of the 999 triage process were logged on the computer aided dispatch system. The system prompted the call handler with questions for the caller and the response was recorded on the system. The system was password protected.
- Records on the dispatch system used by the dispatch team were colour coded to indicate the priority of the call and assist in dispatching the appropriate response.
- The system contained 'flags' to identify pre-existing conditions or safety risks to assist staff in assessing the call and alerting ambulance crews to further information.
- Paper records were only used as part of a backup if the electronic systems went down and records were added to the electronic system manually when systems returned to normal.
- Information provided by the trust showed that information governance was part of the induction and mandatory training. Mandatory training records showed that compliance rates for information governance was 87.2% compared to the trust target of 85%.

Assessing and responding to patient risk

Emergency operations centre

- All calls to the EOC were made via 999 and assessed using a Medical Priority Dispatch System (MPDS). This questioning established the presenting condition of the patient and what response was needed.
- Since April 2016 the EOC were using the Ambulance Response Programme (ARP). The ARP aimed to improve response times to critically ill patients. It aimed to make sure the most appropriate response was provided for each patient first time.
- The system used a new pre-triaged set of questions to identify those patients in need of the fastest response, at the earliest opportunity. The most appropriate vehicle was then dispatched to the patient within a timeframe that met their clinical need (Dispatch on Disposition).
- A new evidence-based set of clinical codes were used to better describe the patient's presenting condition and response/resource requirements. These were used to improve outcomes for all patients contacting the 999 ambulance service.
- A procedure was in place for calls which were non urgent, to be safely disconnected at times of high emergency call volumes in relation to the number of staff on duty. This was in preference to the call handler taking an urgent call. The procedure was called 'Urgent disconnect' and had been agreed by the Clinical Director.
- The outcome of the call was dependant on the triage and risk assessment. If a patient required an ambulance, then one would be dispatched during the call. The call handler would stay on the phone with the patient until the responder arrived.
- Call handlers were able to assess and transfer patients to other services within the EOC. This included the NHS 111 service and clinical hub (Mental Health nurses, and clinical advisors who were paramedics).
- We saw staff using the electronic triage and risk assessment systems appropriately during our inspection.
- Staff were aware of the skill mix of ambulance response staff and could describe what response they dispatched for different situations.
- Resources were dispatched based on the clinical priority of the call and the ambulance crew's location.
- The centre in Wakefield had staff working in areas dedicated to managing situations with a high level of risks. These were the major trauma desk and the serious incidents 'bronze desk.'
- A paramedic staffed the major trauma desk. Their role was to manage and co-ordinate responses to major incidents to ensure the correct emergency vehicle attended. For example, if there was a need for the air ambulance and medical staff. They were responsible for liaising with other emergency services and hospital where the patients were taken. The role included following up of the patient outcomes from the admitting hospital. The patient outcomes were documented electronically and shared with the ambulance staff involved. This promoted and shared learning from the emergency.
- A team leader staffed the bronze desk; their role was to have oversight of the dispatchers. They ensured the closest crew to the emergency was dispatched. They also managed any serious emergencies. For example, firearm incidents, multiple vehicle incidents or those involving more than one emergency service. The bronze desk would act as the point of contact for other services; this helped to ensure timely information was shared about the incident.
- The centre in Wakefield had a dispatcher dedicated to managing community responders. They sent the responders to situations occurring in their community and this provided a timely first aid response, to people needing care. For example, patients who maybe suffering a heart attack in order to receive care quickly whilst waiting for an ambulance.
- There was a clinical hub based at Wakefield, which took calls from both Wakefield and York. The team consisted of paramedics, nurses and mental health nurses. They provided clinical support to patients, either to assess the best level of response by the service, or to provide welfare support to patients who were waiting for an ambulance response. This team also provided the 'hear and treat' service.
- The service had developed a 'frequent caller team'. The role of this team was to support patients who may have complex physical/mental health needs requiring specific interventions by ambulance crews, or who could be managed by 'hear and treat' interventions. Patients who met the criteria for a 'frequent caller' had a care plan and there was a notification 'flag' for their name /address to alert the EMD to the response required. This team worked closely with other health organisations and local authorities to ensure patients received the appropriate care.

Emergency operations centre

Staffing

- At York EOC, there were 67.5 (WTE) staff. The centre was open 24 hours a day, seven days a week. Staff shifts were variable and flexible to meet the demand of the service and the skills of the staff.
- Skills within the EOC included Emergency Medical Dispatchers (EMD), Dispatchers, paramedics, general and mental health nurses, managers and clerical support staff.
- At the Wakefield EOC there were 284 (WTE) staff. The centre was also open 24 hours a day, seven days a week. The skills of the staff within the EOC were EMD's, Dispatchers, Clinical Hub staff, managers and support staff.
- Information provided by the trust prior to inspection showed vacancies across the service to be: 2.6 WTE (out of a budget of 13.5 WTE; -19.5%) staff on the health desk, 16.8 WTE (a budget of 127 WTE; -13.2%) EMD staff, 6.7WTE (a budget of 127.2WTE; -5.3%) dispatchers, 2.7WTE (a budget of 26.5WTE; -10.1%) team leaders, 0.6WTE (against a budget of 8.6WTE: -6.5%) senior managers and 1 WTE (out of a budget of 5 WTE; - 20%) control centre staff.
- Although there was no budget for EOC apprentices the service employed two whole time equivalent staff. There was a budget of 5 auditors and they employed 6.2 WTE (+23.6% more staff); In EOC governance there were 0.2 WTE (25%) more staff than budget; in practice delivery there were 1.5WTE (28%) more staff than the budget; and in EOC the service had a budget of 10 WTE managers and they employed 11 WTE.
- We were informed that there were four WTE vacancies for nurse/paramedics and two WTE mental health nurse vacancies. The mental health provision had been introduced in December 2015 and until the service was fully staffed, they used agency staff who already knew the service.
- The EOC did not use agency staff in the dispatch or call-handling. This was because the staff needed extensive training to become competent and maintain their skills. Some of the staff including managers were able to work flexibly within the department to cover EOC and EMD in an emergency.

- We heard from senior managers and staff how vacancies, particularly within the dispatcher staff groups were positively attributed to career progression.
- Three dedicated staff were responsible for planning staff duty rotas and they used an electronic computerised system. Previous data including service demand, weather forecast and events taking place were used to projected staff requirements.
- There were five teams of staff who worked across York and Wakefield EOC's. From February 2016, the teams reduced from six to five. This gave 20% more people in each team to allow greater flexibility and cover. Managers and staff reported that this was working well.

Anticipated resource and capacity risks

- A resource escalation action plan (REAP) was in place. REAP is a structured process for all UK ambulance trusts using the joint decision model as part of the Resource Escalation Action Plan (REAP).
- The YAS REAP provided the trust with a structured set of considerations and arrangements to assist in their Business Continuity Management (BCM).
- Anticipated resource and capacity risks during major events had been taken into consideration. These included the use of a fully equipped, designated control room.
- We saw operational plans addressed capacity, resource, risk, command and control during the events.
- Resource requirements were managed through the use of the staff rota system. Resource capacity was based on the same date from the previous year's activity. Staff told us they could adjust this system to allow for further resource or capacity if there was a major event or potential increase in capacity requirements.
- The service had a Demand Management Plan (DMP). The plan was designed to be used in situations of excessive call volume or reduction in staff numbers.

Response to major incidents

- Staff in the EOC's attended two away days each year, which focussed on responses to major incidents; for example, dealing with terrorist attacks and firearms situations. The EOC had nationally been recognised for their business continuity plan.
- An annual desktop simulation major incident training exercise also took place.
- In the event of a major incident, Wakefield EOC had a dedicated room they used as a command centre. The

Emergency operations centre

room had the appropriate IT systems in place to manage resources and maintain effective communication; this included the computer aided dispatch system. The equipment included packs for each staff role to inform them of the pathways used in major incidents.

- Joint emergency services serious incident planning had taken place.

Is emergency operations centre well-led?

Good



We rated well-led as good. This was because:

- Operational staff were aware of the vision and values of the service and these were displayed in the EOC for staff and visitors to see.
- Monthly performance review meetings with manager and directors took place to ensure they were on target to meet their performance indicators.
- Trends and learning from the audits were shared with staff at their 'away days' or more regularly when needed.
- We saw that staff survey results were similar to the National average.
- The culture within the EOC was open and transparent where staff felt valued and empowered to speak up.
- The trust had a 'Freedom to speak up' campaign and had appointed 'guardians', which supported staff to send in anonymous questions or concerns about patient or staff safety and receive feedback from the chief executive.
- Staff could send in anonymous questions via the intranet and receive feedback from the chief executive.
- The trust had been involved in a number of innovative pieces of work and these included a member of staff being part of a project supported by the mental health charity MIND. The Blue Light programme was a project run across all emergency services, including the ambulance service. The aim of the project was to improve the mental health of staff working in emergency service by having 'Blue Light Champions' in each area of the service to act as support to staff.

Vision and strategy for this service

- The vision and values were on display in the EOC and staff were able to tell us about the 'We care' values.
- The supporting strategy of the trust was to, "...provide the necessary drivers to deliver the best possible care for our patients and support the concept of working in new ways to deliver the highest quality services."
- An example of how they were doing this in EOC was the implementation of the ARP. It aimed to improve response times to critically ill patients and make sure the most appropriate response was provided for each patient first time.

Governance, risk management and quality measurement

- Governance and risk concerns were escalated where required through regular governance meetings.
- An electronic risk register was in place for EOC. We saw the risks were identified, graded as to their severity and importance, with review dates and actions taken.
- The management staff were able to describe the risks to the service and what they had in place to mitigate the risks. For example;

In June 2016 the risk register showed the posed risk in EOC of call handling performance not achieving the national Ambulance Quality Indicator. This would result in patient delays in receiving the help they needed as they might abandon their call and redial. This could have resulted in an adverse patient outcome and or repeated calls into EOC. We saw review dates and the manager responsible for its progress had been recorded on the risk register. Controls had also been identified and recorded on the register to mitigate the risk. One of the controls identified the use of the 'Urgent disconnect' procedure (which has been explained earlier in this report). Evidence showed the risk had been reviewed and following the agreement of the urgent disconnect procedure, the action plan completion date was met. We saw the urgent disconnect process was in use at the time of inspection and staff spoke positively of its introduction.

- We reviewed the risk register in our meeting with the Locality Director and the Head of the Clinical Hub. We were informed that one of the risks was a corporate risk and as such had been moved to that risk register. We were also told that the other risks on the register were no longer a risk and would be reviewed and removed from the register at their next meeting.

Emergency operations centre

- The Clinical Governance Group was chaired by the Medical Director and reported to the trust management group.
- Monthly performance review meetings with manager and directors took place to ensure they were on target to meet their performance indicators.
- The head of service delivery chaired a twice monthly, safety responding group meeting. This included incident review, patient safety and medicines management. The meeting was attended by EMD's and dispatchers and all incidents were reviewed.
- There were systems in place to monitor and analyse data. All calls to the service were recorded and 1% audited each day (approximately 22 calls a day, 600 to 800 a month).
- One percent of calls taken by individual staff were also audited each month and staff received feedback to the audit in their one to one meetings.
- Trends and learning from the audits were shared with staff at their 'away days' or more regularly when needed. For example, we saw Operational Alerts were used in disseminating information quickly to staff.

Leadership of service

- Each shift at the EOCs had team leaders for each area of EMD's and call dispatch and a duty manager. During the day, there were managers and senior management on site. Management rotated an out of hour's on-call system to ensure they were available when required. The EOCs had a clear leadership structure in place with roles and responsibilities clearly defined.
- We found that staff at both York and Wakefield EOC felt team leaders in call handling and duty managers in dispatch were supportive, approachable and visible.
- Although staff told us senior managers were approachable and visible, some staff told us that they had not seen senior managers in their department. Visitors could arrange to visit the department and see the work carried out. However, due to the nature of the work, people were not encouraged to access the department on an ad-hoc basis.
- The Locality Director offered meetings to staff at both EOC's on a regular basis and this was to listen to their views or concerns. The majority of staff we spoke with told us about these meetings taking place.
- At Wakefield EOC there were 'Team Champions;' staff who provided advice and support to colleagues.

- The Mental health nurse provided support to staff for example, following a difficult/stressful call.
- The trust recognised the need for a diverse workforce and was committed to equal opportunities in employment.
- The trust issued a newsletter to all the staff. Staff told us about the newsletter and that it provided information about what was happening in the trust and any development opportunities.

Culture within the service

- The culture within the EOC was open and transparent where staff felt valued and empowered to speak up.
- The trust had a 'Freedom to speak up' campaign and had appointed guardians. This enabled staff, with support from the guardian, to send in anonymous questions or concerns about patient or staff safety and receive feedback from the chief executive.
- One team leader told us they were proud that staff cared about their job. Staff told us they felt proud of the work they did in EOC.
- The service had several initiatives in place, which included, Favourable Event Reporting (FERF). This initiative encouraged learning from positive practice, by recognising and reinforcing successful events and behaviours. We heard how staff had received positive feedback from their managers and they had acknowledged their behaviours and practice. This had been particularly evident at the staff away days.
- As part of the trust 'Sign up to Safety' campaign, their safety programme lead had recently introduced 'Safety Huddles.' Due to their success, it had been agreed the huddles would meet two to three times weekly. Representatives from each of the teams across EOC would attend. The discussions included areas of staff concerns; patient delays, morale, the availability of the mental health nurse for staff. The huddle was part of the 'Sign up to Safety' campaign and an initiative which encouraged staff to have a voice and be listened to.
- Staff reported they felt listened to. We heard how staff held up a card when they needed assistance for example input from their team leader, or clinical hub. This initiative had been implemented following a suggestion from a member of staff. Staff working at the EOC found the card to be invaluable and positively reflected upon its use.

Emergency operations centre

- Results from the NHS staff survey 2015 were positive. Most areas the trust achieved the same or similar score as the National average for a similar size of trust.
- For example, staff recommendation of the organisation as a place to work or receive treatment. The trust scored 3.2% and the national average was 3.3%.
- The trust scored the same or similar to the national average in, staff motivation at work; recognition and value of staff by managers and the organisation; effective team working; organisation and management interest in and action on health and wellbeing.
- They scored slightly above the national average for percentage of staff appraised in last 12 months; quality of non-mandatory training, learning or development and percentage of staff reporting errors, near misses or incidents witnessed in the last month.
- The trust scored slightly below the national average for the percentage of staff reporting good communication between senior management and staff. They scored 0.1% and the National average was 0.2%.
- The trust scored 0.2% in comparison to the national average of 0.3% for the percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse. None of the staff we spoke with during the inspection reported any concerns.
- The EOC had a culture of supporting staff following difficult jobs and calls. Staff told us they were regularly offered time out and supported by their managers and the mental health nurse.
- There were some examples that staff in York felt disconnected from the larger team in Wakefield, and there was some expressions of uncertainty about the future. They felt information was slower to reach the York team and that there was lack of understanding across the teams. The managers were aware of this. The Locality Director attended the York site on a regular basis. They held meetings to listen to staff views and or concerns. The trust issued a newsletter to all the staff to keep them informed.
- Staff engagement was also encouraged via the electronic communication system. We heard how staff could email the chief executive anonymously with a question or concern and they received a reply.
- We saw large electronic screens displayed live trust updates and were visible to staff whilst they worked.
- Staff away days occurred twice a year and each of the five teams attended. The days included learning from incidents, updates and training.
- The service used voluntary people within the community 'responders.' These people were trained by the ambulance service to provide a first aid response to people needing care.
- We saw from the minutes of a trust board meeting, the development of the Quality Strategy had included the involvement of:- YAS forum members, internal and external engagement, internal knowledge regarding complaints, patient feedback and incident reporting.

Innovation, improvement and sustainability

- The EOC were innovative in the way they worked and this was apparent in the working of the 'Bronze desk.' Whilst we were inspecting, we saw staff from other organisations visited the service to gain insight of how it was set up and used.
- The service was one of the leading organisations in the piloting of the ARP. The use of the system aimed to improve response times to critically ill patients by making sure the most appropriate response was provided for each patient first time. This aimed to achieve a positive outcome for the patient. There were three key elements of the ARP programme: the use of the evidence based clinical codes, which better described the patient's condition; Dispatch of the most clinically appropriate vehicle to each patient within a set timeframe; the use of a new pre-triage set of questions to identify those patients in need of the fastest response.
- A member of staff was part of a project supported by the mental health charity MIND. The Blue Light programme was a project run across all emergency services, including the ambulance service. The aim of the project was to improve the mental health of staff working in emergency service by having 'Blue Light Champions' in each area of the service to act as support to staff.

Public and staff engagement

- Staff had access to the trust's electronic communication system which was used to provided updates to staff. We saw staff signatures recorded to show they had received information.
- Team meetings and staff one to one meeting took place within the EOCs.

Resilience planning

Safe	Good 
Effective	Outstanding 
Well-led	Good 
Overall	Good 

Information about the service

Yorkshire Ambulance Service (YAS) NHS trust covers the areas within North, South, East and West Yorkshire and Hull. The resilience function was trust-wide.

YAS Resilience and Special Operations service provided services to deliver its statutory obligations as category 1 (NHS emergency services) responders under the Civil Contingencies Act (2004) working collaboratively with multi-agency services. The resilience service had responsibility for:

- Major incident planning
- Business continuity
- Event planning and special operations.
- Emergency preparedness, resilience and response (EPRR)
- Hazardous area response teams (HART).
- Air ambulances and critical care paramedics.

The EPRR and HART functions operated under service specifications set out by the National Ambulance Resilience Unit (NARU) aligned to NHS England's core standards and key strategic guidance for health.

The EPRR team planned for and responded to a wide range of incidents and emergencies that could affect health or patient care. These ranged from extreme weather conditions and natural disasters to outbreaks of infectious diseases, major transport accidents or planning safety for large public events.

The HART specialist paramedic team formed part of the NHS ambulance service which provided medical care to patients in hazardous or dangerous environments. The HART team have trained staff to meet national requirements in relation to:

- Chemical, Biological, Radiological and Nuclear incidents (CBRN)
- Hazardous material (HazMat) incidents
- Urban search and rescue (USAR)
- Safe work at height incidents (SWAH) and confined space operations
- Inland water operations (IWO), including water rescue and flood response
- Marauding terrorist firearms attack (MTFA)

The HART team were subject to regular training and scenario testing in relation to these areas in order to maintain their skills and meet national standards both as a service and working with partners.

There were two specific bases, one located in Rotherham and another in Leeds.

The bases contained specialist equipment and a range of vehicles to support the Resilience function and included vehicles containing equipment for mass casualty events.

Air ambulance services in the region were provided by the Yorkshire Air Ambulance charity and YAS. The charity provided the infrastructure including the building and aircraft. The staff, with the exception of the pilots, were employed by YAS.

The HART team was co-located with Resilience function at the Leeds base in a new and modern facility. During the inspection we visited both bases, the air ambulance base located in Nostell and trust headquarters.

In January 2015 the CQC carried out an announced comprehensive inspection and overall we rated resilience as Requires Improvement. We rated safe as Inadequate, responsive as Good and the well-led domain as Requires Improvement. The effective and caring domains were not rated as there was not sufficient evidence.

Resilience planning

This inspection took place on the 13, 14, 15 and 16 September 2016 and was part of an announced focused inspection to follow up the outstanding requirements from the previous inspection. We looked at the safe, effective and well-led domains. We were unable to observe direct patient care because the opportunity to accompany a crew to a call-out did not arise. We therefore could not rate the caring domain.

We inspected a total of 12 vehicles as well as equipment, breathing apparatus and medical bags. We spoke with 21 staff including HART operatives, administration and support staff, supervisors and managers. Before our inspection we reviewed a range of information from and about the service.

Summary of findings

Overall we rated resilience at YAS as Good. Safe and well-led was rated as Good and effective was rated as Outstanding.

- We found good evidence of learning both in local and wider resilience teams. This was supported by good systems for reporting incidents and debriefs.
- Mandatory training levels had been met or exceeded. Staff were able to demonstrate their knowledge around mental capacity and safeguarding.
- Significant improvements had been made with regards to checking equipment and the cleanliness of the environment and vehicles. This had been sustained since the previous inspection.
- Medications management practices were safe.
- Staffing levels were good and in line with national guidance.
- Business continuity plans were robust and the service assessed and responded well to potential risks, service demand and capacity.
- Staff were actively engaged in activities to monitor and improve quality and patient care. Care was evidence based and opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- Staff were proactively supported to acquire new skills and share best practice and we were provided with many examples of this. Staff competencies were maintained and tested in accordance with NARU recommendations.
- A number of HART operatives were specialists in particular core competencies such as CBRN and SWAH and provided training and updates to colleagues.
- Staff were patient focused in terms of care planning and delivery, with a commitment to collaborative working based on Joint Emergency Services Interoperability Programme (JESIP) principles which were embedded within the service.
- Information was collated and shared in performance dashboards and in ResWeb which all staff had access to. Information was also shared via the PROCLUS database from national bodies such as NARU.

Resilience planning

- There was a clear vision and strategy for the service which was stretching and supported by staff. This linked to the overall trust vision as well as national guidance.
- There was active engagement with a variety of other organisations and a strong focus on collaborative working.
- Leadership was strong at all levels with experienced and knowledgeable staff in post. There was a focus on continuous improvement and motivation of staff towards a shared purpose.
- It had been identified from the previous inspection the changes in practice in some areas needed to be made. It was identified these could not be brought about by an individual person. All staff were involved and accountable for the changes in practice.
- There was a very positive culture within the teams and staff morale was high. There were high levels of engagement with staff, and staff were encouraged to raise concerns.

The governance arrangements and information related to performance were proactively reviewed.

Is resilience planning services safe?

Good



We rated safe as good because:

- We found good systems for incident reporting and debriefings with evidence of sharing and learning within local teams and the wider resilience service.
- Mandatory training targets had been met or exceeded, and staff demonstrated a good knowledge of safeguarding and mental capacity.
- The environments and vehicles were visibly clean and tidy with robust systems in place for checking equipment. This was supported by audit data. Significant concerns had been raised in this area at the previous inspection. We found swift, comprehensive and sustained assurance processes had been put in place following this.
- There were good safe systems in place for the storage and management of medications.
- Staffing in the HART service was good and in accordance with NARU requirements.
- The service assessed and responded well to potential risks to service demand and capacity whilst ensuring patient safety was maintained.
- The business continuity plans were extremely robust and leads represented nationally and provided support and training to a number of organisations outside YAS.

Incidents

- Never events are serious, wholly preventable patient safety incidents which should not occur if proper preventative measures are taken. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event. There had been no Never Events reported within the resilience service.
- All the staff we spoke with were aware of how to report incidents. This was via a trust web based incident management system. Staff told us they could also report incidents via a 24 hour dedicated telephone line. This was described as a useful service as it saved time.

Resilience planning

Staff also said it allowed incidents to be reported in situations where it otherwise may not have been possible to report them, for example due to where they were working and lack of access to a computer.

- Information on incident reporting was seen on noticeboards at the bases we visited.
- Mandatory training on the investigation of incidents was completed every three years by resilience and HART staff. Training figures provided by the trust showed each staff group to be at 100% compliance.
- There had been 60 incidents for the service from 2 January 2016 to 25 June 2016.

In 31 incidents, (52%) no harm was reported to have been caused. These incidents included damage to vehicles and broken ampoules of medication.

- 21 incidents (35%) were classed as minor harm; examples included minor damage to vehicles and minor injuries to staff from slips, trips and falls. Two incidents (3.3%) were classed as moderate, these both related to staff injury from falls.
- Six (10%) incidents were not classified, they included reports of HART staff dealing with multiple major traumas within a week including suicides, shooting incidents, and house fires, all with fatalities. We discussed support mechanisms for staff following attending incidents. This was available on scene through debriefs with the police and fire services depending on the incident. Senior managers were made aware of any traumatic incidents and post incident care was always offered along with support from occupational health.
- Incident data fed into a safety management report and safety bulletin which was shared with staff and other divisions. The monthly performance dashboard also showed the number of incidents reported each month and if any were outstanding. It also highlighted any which were Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reportable.
- Staff told us they would get individual feedback if they had completed an incident form. Incidents were discussed at clinical supervisors meetings and at clinical governance meetings which took place bi-monthly. We were told as the teams within resilience were smaller, sharing information was easier.
- HART operatives told us 'debriefs' sometimes took place on scene, to review how a situation was being managed.

Debrief forms were also completed following attendance at an incident. We were told the form had been based around a reflective theory model to link in with staffs continuing professional development; however they had been revised to make them easier to complete and identify learning. The revised forms gave a description of the incident and bullet points about what went well and what could have been done differently.

- We reviewed debrief sheets from the HART team and from the air ambulance team. We found that staff were very honest about stating what went well and where improvements could be made. For example one form stated the doctor didn't appreciate new guidelines, another commented on the hour's wait in handing over a patient at an accident and emergency department.
- Incidents were also discussed at daily team briefs. We were given an example of a discussion around an incident with someone who had been walking on a railway line. The learning from this incident was focused around staff maintaining their own safety.
- One of the HART teams told us they had spent a day reviewing an incident they had attended. They discussed each step and decision made as there had been some conflicting views with the other services in attendance over replacing body armour. The team felt this had been a valuable learning exercise, although recognised that in order to share learning it would have been helpful to record their discussions. They felt that some of the 'soft' information about an incident can be useful for learning and they were looking at how this information could be captured.
- Completed debriefing sheets were uploaded onto 'Resweb' which was an internal website which all staff could access.
- Information on debriefings were also uploaded on to the National Ambulance Resilience Unit (NARU) National Lessons Database called PROCLUS. This is a software package for team development and incident management. This package was used by HART services across the country enabling wider learning and the development of an evidence base to improve clinical care and performance.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.

Resilience planning

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation was introduced to all NHS trusts in November 2014. Staff could explain the duty of candour and spoke about being open and honest. There had been no notifiable incidents within the resilience service.

Mandatory training

- Mandatory training for resilience staff (including HART) covered topics such as infection prevention and control, moving and handling, equality and diversity, information governance and medicines management.
- The YAS target for mandatory training was 85%; this target had been met or exceeded for each staff group for each training topic. For example overall compliance for 49 paramedics and nine managers was 100%.
- Mandatory training was monitored through a monthly dashboard and email reminders sent to staff if any training was coming up for renewal. Resweb was used to share with staff any changes to mandatory training requirements.
- Training compliance was also logged in an electronic system (Oracle Learning Management) which we observed on site.
- The HART service complied with NARU National Training Standards in accordance with NHS Service Specification for HART 2015/16 Competency Standards 21-25. We spoke with the learning educators for HART and resilience who monitored compliance with training and competency.
- In line with the NHS service specification operatives completed mandatory six monthly physical competence assessments (PCA). Some of the teams had staff who had completed personal training qualifications and a gymnasium was on site at the HART base in Leeds.

Safeguarding

- Trust policies and guidance on safeguarding were easily accessible and staff could describe how they would escalate any safeguarding concerns. The safeguarding policy had a flow chart illustrating how a concern would be escalated. When asked staff could describe this

process. They told us they would contact the Clinical Hub and talk through the details when they had any safeguarding concerns. The Clinical Hub would then complete the referral.

- All the staff we spoke with had an awareness of safeguarding and we were provided with examples of when referrals had been made. For example a situation when a child had been taken hostage by a parent. We were also told about a multi-agency case review which had been done for a frequent caller where there had been safeguarding concerns. The resilience team were also informed about any local serious case reviews.
- Staff received mandatory training in safeguarding of vulnerable adults and children. Safeguarding adults level one, and safeguarding children level one and two training compliance was mostly at 100% for resilience and HART staff. The only exception were four whole time equivalent staff (WTE) which included an apprentice and ambulance care assistants. Training compliance for these was 80% for children's safeguarding level two.
- Mandatory training was also provided on learning disability and mental health awareness and mental capacity. Additional training on dementia awareness was also provided. Compliance figures for each of these topics were 100%.

Cleanliness, infection control and hygiene

- At the previous inspection a number of concerns had been identified and raised in relation to cleanliness and infection prevention and control. These had been immediately addressed at the time of the last inspection. On the follow up inspection we found that these changes had been sustained.
- The bases we visited at Rotherham, Leeds and Nostell were in a good state of repair and areas for general use were visibly clean and tidy.
- The garage areas for storing the vehicles at the Leeds and Rotherham bases were spacious, visibly clean and free from clutter. Each had a sluice area and cleaning equipment kept within metal cabinets. A hand wash sink was also available.
- We inspected six HART vehicles at Leeds and six resilience vehicles at Rotherham. This included a mass casualty vehicle (MCV), a decontamination vehicle, business continuity vehicle, heavy equipment vehicle and covert operations vehicle. The vehicles we inspected were very well maintained and visibly clean both inside and out.

Resilience planning

- This was supported by monthly audit data for vehicle and premises cleanliness. We reviewed data provided for the months of May and June 2016 and compliance rates for the resilience service were 100%. This was based on the two bases and audit of ten vehicles (five from each base).
- We also reviewed a vehicle inventory which detailed each vehicle and its contents.
- Staff had access to personal protective equipment (PPE) and alcohol gel and detergent wipes were available.
- Monthly audits were in place for hand hygiene for the HART and resilience teams. Each audit had questions/prompts attached to it and where to go to seek further advice. For example, where further supplies of hand wash towels were available and to ensure dirty mop heads were removed and disposed of after use. Audit results were seen displayed on noticeboards at the bases we visited.
- At the air ambulance station we were told hand hygiene was discussed as part of the debrief after each call out. This was evidenced on the bottom of the debrief forms used
- We could not observe the use of hand hygiene or infection control and prevention in practice because the opportunity to accompany a crew to a call-out did not arise.
- We reviewed hand hygiene audit data for the resilience service for the months of May and June 2016. This was based on ten observations. Compliance rates were between 78% and 100%, the main area identified was the wearing of wrist watches and staff not carrying personal hand gel. During the inspection we did not observe any staff wearing wrist watches.
- We spoke with HART operatives about cleanliness and infection control. Staff knew how to get specialist advice and how to access the trust's infection prevention and control policy.
- Staff also explained the decontamination arrangements when a vehicle had CBRN exposure and made reference to vehicle decontamination protocols. One of the supervisors was a clinical lead for CBRN and we saw decontamination equipment which had been set up as part of a training exercise.
- A number of issues had been identified at the previous inspection in relation to equipment checks. Following this, equipment checks, and recording the findings had been implemented.
- During our inspection we found that each HART vehicle had its own documentation file identified by the vehicle number. Daily checks were done of equipment on HART vehicles and each month vehicles would be completely emptied and a full check of all equipment on board was done. Tags with identity numbers provided ongoing assurance that the necessary equipment was available and any consumable items within date.
- We removed tags from a random selection of equipment on the vehicles at both bases. We inspected and checked several pieces of equipment including syringes, burn shields and cannulas. Each item was found to be sealed and within the expiry date.
- We observed daily checks taking place during our inspection and each of the vehicles had a completed checklist on board. We spoke with staff about the daily and monthly checks and they said it had just become routine and part of their role. Staff said as they had taken on board the findings of the last report as a team; everyone had taken responsibility for the findings and been involved in addressing them. It was felt this was how the changes had been sustained. We were also told the checklists had been adapted following feedback from staff.
- We reviewed additional monthly checks of four HART vehicles from January, March and April 2016 and found these to be fully completed. Any issues were noted to be promptly addressed. For example, one vehicle had been moved and was not on a charging point and had a flat battery. It was documented that the vehicle had been plugged in and reported.
- Resilience vehicles were checked weekly and we observed 'ResWeb' where completed vehicle audits were stored. We reviewed data of vehicle checks from July 2016 to September 2016 and found these to be fully completed.
- Vehicle maintenance was managed by Fleet. There was a base in Sheffield and one in Wakefield. There was a master inventory for use by Fleet. Due to the contents of the vehicles there were strict processes in place for when vehicles needed to go there.

Environment and equipment

Resilience planning

- We reviewed the standard operating policies (SOP) for the maintenance and replacement of equipment. This included flow charts clearly indicating what to do if any issues were identified and who to contact.
- Each of the bases we visited were in a good state of repair, they were spacious and provided a suitable working environment to meet the needs of the service and staff. The facilities met NARU/NHS Service Specification for HART 2015/16 Resource Standards in terms of estate, technology, capital and revenue depreciation schemes. All equipment met national requirements and was maintained in accordance with manufacturer's recommendations and best practice.
- We observed the store rooms at Leeds and the air ambulance base at Nostell. They were very tidy and well organised. We were told stock checks were done each month and there had been close working with the supplies department to reduce wastage whilst ensuring they had enough stock of what was needed.
- We inspected equipment for evidence of safety appliance checks. This was the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at a number of defibrillators and suction machines on vehicles and in the hangar at Nostell and found them all to have checks which were in date.
- Equipment was stored in several designated areas including vehicles, storerooms and secure cages. Training and actual equipment were kept in separate rooms.
- At the HART base there was a separate secure area for equipment which was awaiting repair or no longer in use. These were known as 'red card items', for example there we saw a SWAH kit which was out of date. There was also a log sheet attached to provide an audit trail.
- We also observed the breathing apparatus (BA) cylinder room and there was a clear a process for replenishing the oxygen tanks. Staff were clear about which tanks were empty and there was appropriate segregation, storage and labelling. Medical gas cylinders were stored securely in a racking system. There were ten sets of BA and full cylinders for HART operative use in accordance with NARU standards.
- At the previous inspection issues had been identified in relation to BA, we found these had been addressed.
- We reviewed the SOP related to monthly checks of BA, which clearly detailed what checks needed to be done as well as logging and recording and the procedure for the reporting of any faults.
- We reviewed audit data of the ten sets of BA equipment from April 2016 to September 2016. Checks were completed at least monthly on all sets of equipment with the exception of one monthly check having been missed on one set of BA. There were five other occasions when checks had not been completed but this was due to equipment being unavailable as it had been sent for repair.
- 200 live Powered Respirator Protective Suits (PRPS) were in sealed boxes ready for use. They had the size and expiry date clearly visible and we were told a check of all the suits had been done in July 2016. PRPS suits for training were kept in a separate area. PRPS are a gas tight chemical protective suit for use after a CBRN incident.
- Five sets of decontamination kit were available. These had monthly and annual checks on them in addition to an annual service. The kits were also checked if they were used on a decontamination course or training exercise.
- We spoke with staff at all sites about the availability of patient specific equipment and we were told this was not an issue. Paediatric and bariatric equipment was available.

Medicines

- There were effective systems in place for the storage and monitoring of medicines which was in line with trust policy. In each base, (Leeds, Rotherham and Nostell) controlled drugs were stored securely. Access was only provided to those staff who were qualified to administer controlled drugs. During our inspection we could not access the controlled drug store at Rotherham as the staff we spoke with were not qualified to administer and therefore did not have a key for the drugs store.
- At Nostell air ambulance base and the HART team base at Leeds access to the controlled drugs store was by swipe card only. In accordance with trust policy only operatives who needed to be able access controlled drugs had a swipe card. The use of swipe cards was recorded and monitored by supervisors.
- Daily checks of stock levels were completed and we saw documented evidence of this with no omissions. A SOP

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had been developed within the HART team to reduce the potential of errors in the signing in and out of controlled drugs. The SOP had been approved by the medical director. The new policy meant controlled drugs were kept on three of the HART vehicles in a locked metal box and at the start and finish of each shift the controlled drug keys were signed in and out.

- We were told of changes in practice following incidents. For example following a drug error, the drugs involved were relocated and stored in separate pouches to prevent a repeat occurrence.
- Medication and oxygen expiry dates were included in the monthly check lists. We checked a number of medications and oxygen cylinders on various vehicles and all were found to be in date.
- Each of the vehicles we inspected recently had a new nerve agent antidote included as part of the standard medicines carried on board staff had been fully briefed in relation to its use by YAS pharmacy staff. In addition posters were displayed around the stations we visited informing staff about the antidote. The agent was stored separately from other medications in a yellow clearly labelled bag.
- There were systems in place for the maintenance of mass oxygen. This included a list of annual services and when five year services were due. The list included the batch number and location of each oxygen cylinder. This information was stored on ResWeb which we observed during our visit. It was identified that a mutual aid request had been made from another service and eight oxygen cylinders had been sent there. This was evidence that the auditing and recording system worked.

Records

- We were not able to observe patient care record forms (PCRs) being completed by HART operatives or the air ambulance team on scene. Patient records were not stored on vehicles and we did not have the opportunity to review any patient records.
- Staff did not raise any concerns or issues in relation to documentation. There were no incidents related to documentation and staff received mandatory training on information governance.
- We reviewed records in relation to vehicle checks and controlled drugs which were in order. Copies of audit forms relating to vehicle checks and controlled drug checks were scanned and stored electronically.

Assessing and responding to patient risk

- Comprehensive and thorough risk assessments were carried out in line with national protocol, NARU and EPRR recommendations, business continuity plans and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- SOP's following national guidelines were in place for specific patient risk activities such as working at height or at a chemical incident.
- The staff we spoke with stated assessing and responding to risk was integral to their role and were able to articulate this with examples when we spoke to them.
- Command and control structures were clearly defined in accordance with national standards. The staff we spoke with were clear about the roles, responsibilities and associated processes within that command structure when responding to incidents. This information was included on the daily briefing sheets we observed. Examples of this were who the Gold and Silver teams were for that day and who the duty manager was at the Emergency Operations Centre (EOC).
- Critical Incident activation guidance, referred to as the 'blue book' was used by the EOC and those in operational management roles. This ensured consistency and provided clear guidance on any additional support or specialist equipment which may be required at any given incident.
- When assessing and responding to patient risk with other agencies the resilience service followed the Joint Emergency Services Interoperability Programme (JESIP). The JESIP principles focus on joint working between the different agencies involved in responding to emergency situations to promote effective responses to risk.
- METHANE acronym was introduced by JESIP, shared across partner agencies and emergency services to establish a common basis for the exchange of information between and within organisations. The acronym stood for; M-major incident declared, E-exact location, T-type of incident, H-hazards, A- access, N-number and E-emergency services now present and those required.
- The resilience service developed memorandum of understanding (MoU) with multiple specialist agencies when dealing with patients in specific risk situations such as search and rescue teams.

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- HART operatives were all qualified paramedics with extended skills and equipment to deal with deteriorating patients and medical emergencies. This allowed changes in patient condition to be rapidly assessed and dealt with in accordance with national policies and best practice guidelines.
- If a patient's condition deteriorated to a point where HART operatives felt they needed additional support or advice there was an escalation process. Medical incident commanders could be contacted.
- There was a close working relationship between the HART teams and the air ambulance. The air ambulance always had a doctor available which meant some interventions which previously hadn't been available always were.
- We observed how the escalation process worked during an incident the air ambulance were monitoring to see if their services were needed. They sought the advice of the doctor who advised a series of specific questions be asked. The questions were then asked of the paramedics on scene and staff were able to clearly establish the air ambulance was not required.
- We were told the service responded to escalated Resource Escalation Action Plan (REAP) levels by standing down the HART teams if the level reached four (extreme pressure). This only occurred when reported nationally and done in agreement with NHS England.
- At the time of inspection there were no vacancies within the HART service. A business case was being put forward to increase the number of operatives from 42 to 45. This was to help provide a little more flexibility with staffing in terms of cover for annual leave and unplanned sickness.
- Due to the nature of the specialist role of the HART staff shifts were covered internally with fill rates at 99%. There was no bank or agency use.
- Staff turnover was low with seven of the roles having no turnover in the past two years.
- The air ambulance operated out of Nostell in Wakefield and Topcliffe airbase near Thirsk. Each aircraft was staffed by two paramedics with one doctor available. Any gaps were covered by overtime due to the nature of the specialist skills needed. Staff were rotated throughout each base on a regular basis.
- The air ambulance had 14 whole time equivalent (WTE) paramedics but there was a proposal to increase this to 17 as from April 2017 which would give the new aircraft night flight capabilities and extend operating hours to midnight.
- The number of Resilience managers had increased from six to nine since the last inspection. They covered an on call rota of one week in three with responsibilities for A&E operations including HART, CBRN, MTF, and the air ambulance.
- Sickness absence across the service was generally low with rates with one member of staff on long term sick. Short term sickness rates between January 2016 and June 2016 had been between 1% and 6%. Between April 2016 and June 2016 it was between 1% and 2% indicating an improving picture.

Staffing

- The inspection team saw the resilience team organisational and staffing structure. This was led by the associate director of Resilience and Special Services. We were told since the last inspection the management roles of EPPR and HART had been reviewed and redefined to ensure each had clear responsibility and ownership in order to respond to the issues raised in the last inspection report. Operationally this ensured that there was not a blurring of responsibilities while acknowledging they continue to have very close working relationships.
- The Resilience managers, business continuity manager and HART manager sat under the head of EPPR and Head of Special Operations. There were also special ops support managers, learning and resource co-ordinators and administrative support staff.
- There were seven HART teams, each comprising of two supervisors and four operatives, with six staff on duty at any one time. This was in excess of the minimum requirement of five, in accordance with NHS Service Specification 2015/16 and NARU interoperability standards 1 – 7 and 12 national requirements for HART.

Anticipated resource and capacity risks

- The trust had an Emergency Preparedness, Resilience and Response (EPPR) policy which detailed statutory duties of a Category 1 responder under the Civil Contingencies Act (2004) aligned to NHS England EPPR Framework (2015).
- The trusts Demand Management Plan (DMP) was aligned with The Local Escalatory Action Plan (LEAP)

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and the Resource Escalation Action Plan (REAP). The DMP aimed to identify and respond to service pressures, be that resource or increased demand, whilst maintaining clinically safe level of care.

- Any risks to capacity or resources were outlined and we saw evidence of this in the weekly REAP review. This took into account potential challenges to the service such as adverse weather, any large planned events and the demand for the same time period the year before. Details of this were included in the daily briefing sheets. For example on 9 September 2016 it was noted there were no weather warnings and on 10 September it was noted there was an annual parade in Scarborough.
- Each department had 21 Business Continuity Plans (BCPs). Each of these had a business continuity lead who had attended a two day training course. The business continuity leads met annually to review plans and make any necessary changes. The leads also represented nationally and provided business continuity consultancy to other trusts.
- YAS Resilience also participated in the Resilience Direct national exercise 'Bravo Charlie' during Business Continuity Awareness week (BCAW) in 2016.
- BCP's were available on ResWeb and hard copies were available. Departmental leads also had copy and the EOC had access to these.
- YAS had identified the key seven prioritised activities and BC departmental plans were focused on these. BC plans were last tested in June 2016; no areas of concerns were identified.
- We reviewed a number of business continuity exercises, which included a large number of individuals and many different services such as police, fire and rescue and local authorities. Clear objectives were outlined, with a thorough review enabling good practice and areas for learning to be identified.
- The Resilience service at YAS was a regional co-ordinator for Joint Emergency Services Interoperability Programme (JESIP) training. Managers felt JESIP principles were referred to amongst the teams and they were proud of fulfilling the requirements of the programme.
- Local risk assessments were completed in accordance with national guidance from NARU to meet service specification standards.
- A major incident live training exercise had been run in 2015 involving YAS, two other ambulance services and three large NHS trusts. Each of the required objectives in

response to the incident were achieved. Areas for improvement were identified through discussion and reflection from those involved. These focused around improved engagement between services.

Is resilience planning services effective?

Outstanding



We rated effective as outstanding because:

- Care was evidence based and staff were continually looking at ways to improve patient care and treatment. Staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- There was recognition that continual development of staff skills, competence and knowledge was integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice and we were provided with many examples of this. Staff competencies were maintained and tested in accordance with NARU recommendations.
- A number of HART operatives were specialists in particular core competencies such as CBRN and SWAH and provided training and updates to colleagues.
- The HART team had protected time for training; one week in seven was dedicated to this.
- Staff were patient focused in terms of care planning and delivery, with a commitment to collaborative working based on JESIP principles which were embedded within the service.
- Information was collated and shared in performance dashboards and in ResWeb which all staff had access to. Information was also shared via PROCLUS from national bodies such as NARU.
- Staff understood the processes for seeking consent and demonstrated a good understanding of mental capacity.

Evidence-based care and treatment

- The trust had fulfilled all requirements in relation to International Organisation for Standardisation (ISO) 22313 for the last three years. YAS was the first ambulance trust to achieve this. ISO 22313 is a business continuity management system which enables organisations to plan, respond and recover from disruptive incidents as they occur.

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- The resilience team used Joint Royal Colleges Ambulance Liaison Committee (JRCALC guidelines) and followed national recommendations from NARU and The National Institute for Health and Care Excellence (NICE guidelines).
- All operatives we spoke with from the HART and air ambulance team told us they used evidence based practice to underpin their care and treatment of patients. We reviewed a number of policies on the trust intranet, including amputation guidelines and thoracotomies in blunt trauma cardiac arrest. They were easy to access, in date with an author and version control evident.
- Operatives told us if they needed to practice outside of a SOP as they felt it was in the best interests of the patient they would always seek advice from the medical response team before proceeding.
- One of the operatives had developed an 'app' to allow easy access to all clinical procedures whilst at an incident. It included a quick reference guide for all extended skills.
- We were told all the SOPs used by resilience, HART and the air ambulance had been standardised to ensure consistency. This had been done through the YAS clinical governance group.
- We were told that the air ambulance conducted a pre check list prior to rapid sequence induction (RSI) and a case review and audit was done of each time this was administered.
- Critical incident activation guidance was used by all operational managers to ensure a consistent and through approach to individual incidents.
- We were told high level codes had been developed which were used by the EOC which would automatically trigger a HART response. We received further information on this which specified over 400 incidents which would trigger HART attendance as well as other specialist training such as inland water operations (IWO). Examples of these included, diving or suspected neck injury and respiratory arrest underwater.
- We were told about the critical care forum which was a platform for any staff to present any business cases or new drugs or treatments they felt would benefit patients. We reviewed two sets of minutes from these forums which detailed discussions around clinical practice and use of new treatments based on research.
- We were provided with numerous examples of how this had enabled a change in practice or additional

treatment to be provided. Any suggestions had to be researched and presented including information such as the impact for patients, and what training and education needs would need to be met.

- Examples of this included presenting the use of intravenous antibiotics being available for patients sustaining an open fracture. A two year retrospective review had been completed, looking at the time it had taken patients with this type of injury to be administered the first dose of antibiotic from the time of injury. From this a Patient Group Direction (PGD) was developed. An antibiotic called co-amoxiclav was now available for use in those circumstances.
- Other examples were the use of calcium and magnesium in some cardiac arrest situations, and developing a SOP for blunt trauma.

Assessment and planning of care

- The NARU training, equipment and procedures used by the HART staff ensured that effective procedures were in place enabling staff to provide effective care. The use of appropriate equipment and highly trained staff ensured that patients were treated as quickly and safely as circumstances allowed.
- The debriefing of actual incidents allowed any areas for improvement to be identified, this then fed into training exercises to improve services and care. For example understanding the techniques used by different services when working at height.
- Resilience staff received training in dealing with patients with mental health issues and those living with dementia or a learning disability. Staff talked about delivering care based on individual needs and in the best interests of patients.
- HART operatives spoke about being able to use team member's skills and strengths in the different incidents they attended. They also gave examples of some situations where operatives had 'swapped roles' as for whatever reason they had not been able to build up a rapport with a patient. They saw this as vital so the staff were happy to transfer care to another team member if there were any issues.
- HART operatives confirmed they would always ensure the most appropriate care pathway was followed. SOPs were standardised within resilience and in line with NARU guidelines.
- HART operatives had access to specialist equipment for personal protection and for advanced treatment for

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patients. This included bariatric and paediatric patients. SOPs and protocols were used when administering care for children. However individual assessment would be made, for example when administering analgesia for children who were of adult size.

- We were told about ongoing work to address the changing needs within the community as well as the types of incident being attended. For example, working with general practitioners (GPs) to try and reduce hospital admissions using the skills of urgent care practitioners.
- The senior management team acknowledged the type of incidents teams were called to was changing, with less need to always have a commander on scene. As a result of this and in light of the 'Taking healthcare to the patient' document for ambulance services, a review of care planning was taking place. This included a 'hub and spoke' model of care which was flexible and efficient, whilst still providing the best care for patients.

Response times

- Information on response times was collated in a monthly performance report. This showed the number of calls each month divided into different categories and the time from allocation to the team being mobile.
- We reviewed data from April 2016 to September 2016 and with the exception of three calls this was achieved in less than 15 minutes. This demonstrated compliance with the NHS HART Interoperability Standard 8 in Appendix 3 of the NHS Service Specification 2015/16.
- Interoperability standard 11 required that HART staff could be on scene within 45 minutes at strategic sites of interest. The location of the HART and resilience bases meant they had quick access to major road networks in the region. This allowed the required vehicles to reach a variety of locations in a timely way.

Patient outcomes

- Information was not routinely collected on patient outcomes within the resilience service. The HART teams responded to incidents where their additional training and equipment enabled them to reach patients and deliver initial treatment. Once patients had been made safe or removed from the hazardous area, core service staff would transport them to hospital.
- HART operatives told us they often followed up patient outcomes via the trauma desk. This enabled them to

reflect on their practice. Debrief forms were also used as a way of reviewing how a situation had been managed to identify any areas of good practice or areas for learning.

- Activity numbers and type of vehicle deployed was captured within performance dashboards. For example in June 2016, the incident response unit (IRU) had been deployed to 120 incidents.
- The critical care team had been operating from the air ambulance base since April 2016. Staff felt that having a doctor was having a positive impact on patient outcomes. However they recognised demonstrating the benefit was a challenge and they were looking at ways of evidencing this.

Competent staff

- All HART operatives, team leaders and managers were qualified paramedics in accordance with NHS HART Service Specification 2015/16 Standard 23. Training and fitness standards were maintained in line with NARU guidance.
- All HART operatives were recruited and trained in line with NARU Competency Standards 21-22 and 29 which required compliance with 280 competencies under each of the different areas. This included SWAH, TMO, IRU, IWO and USAR.
- We spoke with staff who had not been on the HART team for very long who said the training programme had been intensive but had prepared them for their role.
- Every seven weeks, HART teams completed a training cycle. This included coaching, mentoring and clinical supervision as well as addressing any individual training needs of operatives.
- Some aspects of training were arranged with other services such as the West Yorkshire fire service. They were able to create a hot and smoky environment to facilitate training for breathing apparatus.
- There was a training educator in each of the seven HART teams. HART operatives completed 1:7 weekly training cycles to meet the required competencies under each of the capabilities covering IRU, IWO, USAR, SWAH, TMO and vehicles.
- Individual training records were stored in the HART training office and had been standardised in line with NARU Competency Standards 21-22 and 29.
- We reviewed training records and competency compliance records detailing this training. There were extremely thorough and had been standardised to

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enable easier completion and recording. We saw examples of supporting evidence logs and directed action plans for competencies which needed completing.

- Training exercises reflected real life situation as far as possible and links with other services such as the fire service and mountain rescue allowed a variety of locations to be used for training exercises.
- MTFA training was facilitated by using 'train station' this could simulate scenarios where operatives were put under pressure and time constraints to make decisions.
- Each of the supervisors within the HART teams was an educational lead for a different area, for example CBRN or business continuity.
- All resilience staff were trained in accordance with local and national requirements. Competence profiles for HART and resilience staff were on ResWeb, and Oracle learning management (OLM) logged all training, flagging when retraining was required. This provided evidence of local and national requirements.
- The Resilience Command structure followed nationally the recognised standards of; Gold - Strategic command, the service had six gold commanders; each had done Multi Agency Gold Command Training (MAGIC) training. Silver - Tactical command, there were 17, 10 of which were National Inter-Agency Liaison Officer (NILO) trained. Bronze - Operational command, 170 operatives were trained to this level.
- The command and control system encompassing the roles above provided a 24/7 extremely robust response capability.
- The air ambulance team had six WTE paramedics and eight who were seconded on a two year basis. Helicopter emergency medical services (HEMS) training had to be completed alongside a competency assessment in order to demonstrate the specialist skills and knowledge needed for the role.
- Those staff who did not meet the requirement of the role and could potentially compromise patient care would be withdrawn, and we were told this had happened. Support from management, occupational health and human resources departments was provided in such circumstances.
- We were told that data collected by the air ambulance team showed advanced life support skills were required on average every three days. As a response to this all staff had undergone red alert team (RAT) training.

- We were told rapid sequence induction (RSI) was always available. This advanced skill is the established method of inducing anaesthesia in patients who are at risk of aspiration of gastric contents into the lungs. It is the fastest and most effective means of controlling the emergency airway.
- The air ambulance teams told us they had been to other areas to provide training, for example on the application of traction.
- Staff within HART and resilience staff had annual appraisals. These were felt to be of value and had a separate focus to that of their training requirements. Staff also had monthly one to one's with their managers or supervisors.
- The average appraisal rate for staff within the resilience and HART service was 74% from April 2015 to March 2016. Some of the staff we spoke with had undergone their annual appraisal. The monthly performance report for the HART team for September 2016 indicated there were eight outstanding staff appraisals.
- The trust had developed a placement experience policy in December 2015. This was to ensure anyone who spent time within YAS had structured and agreed objectives focused on quality learning which did not impact the trusts work commitments.

Coordination with other providers

- We spoke with managers who said the resilience service worked with several providers to assess, plan and deliver its functions. One aspect of this was the provision of mutual aid.
- We reviewed a document which demonstrated the providers adherence to the NHS ambulance service memorandum of understanding (MOU) related to the provision of mutual aid. This outlined the vehicles and assets available and detailed a number of assembly points in other regions if mutual aid was required.
- We were told of the 47 flood warnings in the area on Boxing Day last year and the response to this. This was coordinated from the gold cell and liaison took place with the Cabinet Office Briefing Room 'A' (COBRA), other emergency services and the military.
- We were told about the multi-agency specialist assessment team (MASAT) and its role in relation to pre-planned operations. Senior staff also attended

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meetings such as the Local Resilience Forum (LRF) which were attended by representatives of the local health community, emergency services and local authorities.

- Planned events were seen in the daily briefing sheets and YAS provided standby or onsite support for public events such as festivals and parades.
- The Yorkshire Air Ambulance (YAA) had an arrangement in place with Embrace, Yorkshire and Humber Infant and Children's transport service. A flow chart indicated when the YAA can transport the embrace team to their required location to enable specialist lifesaving care to be given; aiming to reduce the time it takes the team to get there.
- The YAA and embrace update newsletter from June 2016 gave an example of when this collaborative working was used to help a critically ill baby in Scarborough. Data had been collated from the start of 2016 which showed seven flights had been made, with an average time saving of 50 minutes.

Multidisciplinary working

- The inspection team reviewed training exercises plans which had been undertaken detailing the outcomes and learning. They tested operational and multi-agency command in line with JESIP Principles and involved other services such as the fire service as well as emergency operations centre (EOC) within YAS.
- We looked at the findings from one such training exercise, a building collapse. This stated due to the structure of the exercise and the use of mutual aid team's staff had to work with members from other NHS trusts. This enabled the standardisation of urban search and rescue (USAR) to be tested.
- The EOC were involved in the training exercises as the initial calls about the incident came to them, be this from a 999 call or being contacted by another emergency service.
- Patient transport services (PTS) formed part of the trusts overall emergency planning response. For example following a mass casualty incident patient transport services could be used to evacuate patients with minor injuries away from the scene.
- The trust had a Medical Emergency Response Intervention Team (MERIT) they operated out of the air ambulance base. They had helped to develop the paramedic role and provide additional support and advice when needed.

- We were told a resilience awareness day was run for new staff to the trust. Half of the day was about the resilience role and function and the other half about EPPR. Staff we spoke with felt this raised the profile of the service and peoples understanding. Managers felt that the services of the resilience and HART teams were being called upon more as a result of greater understanding.

Access to information

- Internal organisational information, role specific material and clinical evidence to support staff could be accessed on the trust intranet, ResWeb and via PROCLUS. As already described an 'app' had been developed by a team member to enable quick access to clinical guidelines on scene.
- All staff in operational roles had copies of the critical incident activation guidance, including staff in the EOC.
- Staff confirmed trust wide bulletins were cascaded within the team and regular emails were received with various updates.
- We reviewed completed daily briefing sheets which detailed who were on call that day as well as any intelligence information.
- The air ambulance linked with the computer aided dispatch (CAD) system in the EOC meaning they could monitor any calls. They could also type in or ask for further information to ascertain if it would be suitable for them to attend. They also had the ability to contact paramedic crews at the scene of incidents to again ask for specific information. We observed this taking place during our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental health awareness and mental capacity was part of the trusts mandatory training schedule. Compliance figures for staff in the resilience service were 100%.
- The trust had specific policies relating to Mental Capacity and Consent to examination or Treatment and staff were aware of how to access these.
- We had discussions around consent, mental capacity and deprivation of liberty safeguards with HART operatives who demonstrated a good level of understanding. Staff described how they would always take on individual's choices and views. We were told

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they acted in accordance with people's best interest during emergency situations. This meant that decisions about care were often made by the paramedics in accordance with their training.

- Further advice was available if there were any concerns raised. This could be accessed from specialists, the trauma desk or the safeguarding team.

Is resilience planning services well-led?

Good



We rated well-led as good because:

- There was a clear vision and strategy for the service which was stretching and supported by staff. This linked to the overall trust vision as well as national guidance.
- There was active engagement with a variety of other organisations and a strong focus on collaborative working. Within this was a clear focus on patient care and best practice.
- Leadership was strong at all levels with experienced and knowledgeable staff in post. There was a focus on continuous improvement and motivation of staff towards a shared purpose.
- It had been identified from the previous inspection the changes in practice in some areas needed to be made. It was identified these could not be brought about by an individual person. All staff were involved and accountable for the changes in practice.
- There was a very positive culture within the teams and staff morale was high. There were high levels of engagement with staff, and staff were encouraged to raise concerns.
- Staff were engaged and focused on delivering high quality care and were proud of the work they did.
- The governance arrangements and information related to performance were proactively reviewed.

Vision and strategy for this service

- The vision for the trust was 'providing world-class care for the local communities we serve'. This was clearly reflected in the staff we spoke with who all spoke about patient focus and striving for excellence.
- The strategic priorities for the trust were supported by an operational plan with a focus on service improvement and innovation, partnership working, and engagement with a diverse and highly skilled workforce.

- The trust resilience planning was firmly based on the Civil Contingencies Act, National Ambulance Resilience Unit (NARU) and Joint Emergency Services Interoperability Programme (JESIP) guidelines. Emergency preparedness, resilience and response (EPRR) frameworks and Hazardous Area Response Teams (HART) interoperability standards fed into this. Senior trust staff were heavily engaged in the development and implementation of national policies and operational procedures. These had all been encompassed into one document of 21 standards to provide a specific resilience vision and strategy aligned with the overall trust and national guidance.
- Staff working within the resilience function were aware of the values and vision of the trust.
- Staff talked about their specific roles and responsibilities and how they contributed towards achieving local and national aims and objectives.

Governance, risk management and quality measurement

- Significant concerns had been identified at the previous inspection in terms of assurance processes. This related to equipment and cleanliness. As previously stated this had been resolved with robust audit and assurance systems embedded and maintained. The ResWeb portal had played an important role in the governance of information and documentation.
- There was a clear governance structure for the resilience function within YAS. Team meetings fed into monthly managerial meetings. We reviewed a number of meeting minutes across the resilience service and saw how information was shared and communicated with external stakeholders such as the Local Resilience Forums. One example of this was the national pandemic influenza exercise.
- The PROCLUS system was used to report governance and performance, and HARToperatives inputted information about incidents and any actions onto this. This fed into and helped inform training. This was in accordance with NARU/NHS HART Service Specification Interoperability Administrative Standards. PROCLUS also enabled the availability of the different teams to be seen both locally and nationally. For example, HART and MTFA.
- We reviewed the resilience risk register and discussed it with senior managers. There were eight risks identified which appropriately reflected the risks to the service.

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One risk was the MTFA requirement of ten Ambulance Intervention Teams (AIT). This has remained on the register for a number of years. There was no dedicated service for this and the majority of these staff were volunteers. We were told this issue had been raised nationally and a senior manager had written a paper to commissioners demonstrating all that could be done to mitigate against this had been.

Leadership of service

- The resilience service was managed by the associate director of resilience and special services. Head of EPPR managed resilience and business continuity with the head of special operations managing the HART function.
- It was felt command support at a strategic level via the Health Gold Cell was a strength of the service. As well as the knowledge and specialist roles of managers within the service. Resilience staff were experienced in their roles with many having been in post for a number of years.
- We found strong leadership throughout the resilience service, staff at all levels told us they felt supported and understood their role.
- Staff reported line managers being approachable and that they were supported in progressing any ideas to enhance the service.
- There was clear evidence of an 'open door policy' with managers being visible and available for staff to speak with. All staff confirmed they felt able to escalate any concerns.

Culture within the service

- We found staff morale to be very high in all areas of resilience we inspected. This was reflected in the low staff turnover rates, with seven of the roles having no turnover for two years.
- The operatives we spoke with were happy to work on other teams and no issues were identified with this. Morale appeared very high.
- The resilience service was professional and thorough. There was constant drive to improve and a 'can do' culture with teamwork at the centre of this.
- HART staff would cover any gaps in their rota and were happy to work on any team.
- We spoke with staff new to the service that had been well supported and welcomed on to the HART team.
- Staff at all levels spoke openly about the previous inspection and how being told the findings and

outcomes had been a difficult experience. The senior management team had taken immediate action and sustained this by having honest discussions with staff. The changes needed had been embraced by the whole team with each staff member taking some level of ownership. This was felt to be very positive and the reason why the changes had not only been sustained but continued to improve.

- Debriefs were a vital part of the resilience function and took place following or sometimes during attendance at an incident. Staff were actively encouraged and expected to engage in structured debriefs. Managers offered additional support for individuals who may have been particularly affected by a traumatic event. Staff told us that close team working helped them to support each other following having to deal with a traumatic incident. They highlighted an example involving children.
- We were told about a psychosocial risk assessment report which had been undertaken within the HART team in 2015/2016. The findings had been carefully reviewed by managers with a focus on areas of concern. Some of these had been able to be easily addressed, for example communicating with staff clearly about rotas.

Public and staff engagement

- The Local Resilience Forum (LRF) enabled engagement with other professionals in relation to their national responsibilities, including the fire service, police, council staff the military and other NHS partners.
- Whilst on inspection the new HART vehicles were delivered, these were to replace some vehicles which had reached the end of their operational life. From speaking with staff they had been consulted about this and much thought and planning had gone into the design and layout of the new vehicles. The staff felt they would further improve the service due to the improved layout, size and manoeuvrability of the vehicles.
- It had been recognised amongst the HART team that their profile needed raising to improve understanding about their role. They had nominated themselves at the trust 'we care awards' as a way of trying to raise their profile internally. The service was also looking at using social media to raise awareness about their role.
- The air ambulance had an extremely successful relationship with the public and support from the charity had enabled its development and growth.

Resilience planning

Innovation, improvement and sustainability

- Staff in the resilience department were actively encouraged to bring new ideas and ways of working to the team for consideration. The critical care forum provided the platform for any clinical improvements or changes to patient care pathways to be presented.
 - The YAS loggist role had been refreshed alongside the YAS command support assistants. This would provide a wider skill-set and capability and ensure a more robust command function at both tactical and strategic levels.
 - ISO22301 accreditation had been achieved and sustained for the last two years.
 - The resilience team were also highly commended in the YAS 'We Care awards' 2016.
- YAS resilience provide support at large public sporting gatherings such as football matches and staff were involved in the Tour De Yorkshire.
 - ResWeb, an information platform, had been developed. This held all resilience plans and guidance, as well as supporting information for meetings, events training and exercises.
 - A Recall to Duty pilot was being developed. This would enable YAS volunteers to provide a level of clinical response cover in their local areas in line with their own skill levels. In contrast to community first responders this would allow a greater scope of response capabilities and a higher clinical level of experience which would supplement the existing response schemes and initiatives.

Outstanding practice and areas for improvement

Outstanding practice

- The rapid arrest team provided clinical leadership in the response to cardiac arrest patients, which had improved the success rate in the return of spontaneous circulation (ROSC).
- The restart a heart team was commended for its CPR work with school children. More than 31,000 children were trained in hands-only CPR in conjunction with the British Heart Foundation.
- Community first responders were trained volunteers who were available to attend emergency calls and to provide initial care before the arrival of an ambulance. More than 300 community first responder schemes which worked closely with the ambulance service.
- The service supported 670 public access defibrillators across the Yorkshire region which was available for use by members of the public. The scheme particularly helped people to access defibrillators in remote villages.
- A member of the air ambulance crew had completed training in Crew Resource Management (CRM). The qualification enabled the member of staff to undertake critique and feedback of incidents whilst taking account of human factors.
- HART staff presented evidence on the benefits of early antibiotic administration in open fractures. This treatment now has become standard practice within YAS.
- The trust was part of the urgent and emergency care vanguard programme, to support the development of new approaches to the provision of urgent and emergency care. The West Yorkshire urgent and emergency care network aimed to develop an integrated urgent care model for the region, building on the services provided by existing urgent care services.

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Within patient transport services (PTS) the trust must ensure that all ambulances and equipment are appropriately cleaned and infection control procedures are followed.
- The trust must ensure secure seating for children is routinely available in ambulance vehicles.

Action the hospital **SHOULD** take to improve

- The trust should review the training requirements for operational staff in the PTS service for vulnerable groups such as patients living with dementia and patients experiencing mental health concerns.
- The trust should review the arrangements for operational staff to check their vehicle and equipment at the start of the shift to ensure they have sufficient time to complete the checks.
- The trust should review the audit procedures for reviewing the recording of controlled medicines.
- The trust should continue to ensure that equipment and medical supplies are checked and are fit for purpose.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 (1) Care and treatment must be provided in a safe way for service users</p> <p>How the regulation was not being met:</p> <p>It was not always possible for ambulance crews to access secure vehicle seating for children.</p> <p>Specialised equipment to support bariatric patients needed to be made available and accessible to all emergency ambulance crews.</p> <p>Vehicles in the PTS service were visibly clean but the service did not have a robust system to monitor the daily cleanliness of vehicles and staff did not have sufficient time to clean the vehicles thoroughly.</p> <p>There were items of equipment stored in some vehicles in a way which posed a risk to patients and staff, such as oxygen cylinders which were not securely fastened.</p> <p>In nine vehicles in urgent and emergency care services we saw sharps boxes were either full, or open, or not dated and signed. Clinical waste was found in the cab or saloon of the vehicle in some instances.</p> <p>There were still examples across services where equipment was not available for staff to use or consumables or medication were past their expiry dates.</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 (1) Systems and processes must be established and operated effectively to:</p>

This section is primarily information for the provider

Requirement notices

(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.

How the regulation was not being met:

The allocated time of six minutes for crews to check their vehicle and equipment at the start of their shift was insufficient for all essential equipment to be checked.

There were occasions where paper records were not always stored securely.

The recording of medicines administration contained some discrepancies which were not always identified through audit procedures.

Learning from incidents, complaints and audit was not always consistently shared across staff groups particularly in the PTS service.

Within the PTS Service there were identified risks missing from the risk register, so it was unclear what actions had been taken to mitigate these risks.

There were vehicles which were found to have faulty equipment and fittings in place, which were still in operation and had not been properly reported particularly in the PTS service.

There was no standardisation regarding the type of equipment to be carried on PTS vehicles. There was no consistency in the amount of equipment and supplies stored on board vehicles and where on the vehicles these should be stored.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Requirement notices

Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

How the regulation was not being met:

The planned establishment for paramedics was 1208 wte. The actual number of staff in post was 1092 wte which meant there was a vacancy of 116 wte.

There were vacancies equating to 20.9 wte staff or a rate of 16.4% in administration and clerical positions of all grades in the PTS communications and control team.

Staff attrition rate in the NHS 111 service was approximately 40% per year.

Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

How the regulation was not being met:

Within the EOC not all of the nursing staff was up to date with safeguarding training.

Within PTS services there were no formal arrangements for one to one meetings or supervision sessions between the team leaders and ambulance care assistants, neither was there a formal record of individual staff performance.

There was a lack of role specific training for staff within PTS services to enable them to carry out their role effectively.

Staff in PTS services was undertaking excessive manual handling activities due to insufficient training in the use of a particular carry chair and the limitations of the carry chair.